COVER PAGE (form 424 in PHS5161-1)

ABSTRACT

The Commonwealth of Virginia has been engaged in a major restructuring and transformation of its mental health system since 2002. The restructuring was initiated and is actively supported by Governor Mark Warner and Secretary of Health and Human Resources Jane H. Woods. The restructuring effort includes consumers, family members and providers, the Mental Health Planning Council, seven regional Restructuring Partnership planning teams, five Special Population Workgroups and a statewide Restructuring Policy Advisory Council. Virginia's restructuring Vision is as follows:

> *Our vision is of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family, and other meaningful relationships.*

Virginia's MHT SIG proposal builds upon the existing restructuring infrastructure and expands the focus into a comprehensive, cross-agency effort that includes Medicaid, public safety and corrections, housing, vocational rehabilitation, social services and higher education. MHT SIG funds will support the development of the Comprehensive Mental Health Plan with all of the above stakeholders.

Virginia's MHT SIG proposal guarantees consumers, parents and family members a significantly higher level of involvement in the restructuring and comprehensive planning process than has been achieved to date. The membership of the Transformation Working Group (TWG) and all committees, task forces and project teams associated with MHT SIG activities will be half consumers and family members.

To support the above, Virginia will use MHT SIG funds for (1) salaries of the TWG Chair and staff, (2) development of consumer and parent networks, (3) leadership training for consumers and key transformation leaders, (4) two Centers of Excellence in partnership with Universities (5) a cross agency needs assessment and resource inventory, (6) development of a cultural competency plan, (7) a targeted public education campaign, (8) specialized planning (e.g., rural, elderly) and evaluation projects, and (9) information technology initiatives.

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BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1.		$	$	$	$	$ 0.00
2.		$	$	$	$	$ 0.00
3.		$	$	$	$	$ 0.00
4.		$	$	$	$	$ 0.00
5. TOTALS		$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION B - BUDGET CATEGORIES					
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	$ 670,000.00	$	$	$	$ 670,000.00
b. Fringe Benefits	$ 218,156.00	$	$	$	$ 218,156.00
c. Travel	$ 64,375.00	$	$	$	$ 64,375.00
d. Equipment	$ 29,855.00	$	$	$	$ 29,855.00
e. Supplies	$ 8,700.00	$	$	$	$ 8,700.00
f. Contractual	$ 1,665,000.00	$	$	$	$ 1,665,000.00
g. Construction	$ 0.00	$	$	$	$ 0.00
h. Other	$ 133,833.00	$ 53,900.00	$	$	$ $187,733.00
i. Total Direct Charges *(sum of 6a -6h)*	$ 2,789,919.00	$ 0.00	$ 0.00	$ 0.00	$ $2,656,081.00
j. Indirect Charges	$ 210,081.00	$	$	$	$ 210,081.00
k. TOTALS *(sum of 6i and 6j)*	$ 3,000,000.00	$ $53,900.00	$ 0.00	$ 0.00	$ 3,053,900.00
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON- FEDERAL RESOURCES				
(a) Grant Program	**(b) Applicant**	**(c) State**	**(d) Other Sources**	**(e) TOTALS**
8.	$	$	$	$ 0.00
9.	$	$	$	$ 0.00
10.	$	$	$	$ 0.00
11.	$	$	$	$ 0.00
12. TOTALS *(sum of lines 8 and 11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
13. Federal	$ 0.00	$	$	$	$
14. Non- Federal	$ 0.00	$	$	$	$
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	**FUTURE FUNDING PERIODS (Years)**			
	(b) First	**(c) Second**	**(d) Third**	**(e) Fourth**
16.	$	$	$	$
17.	$	$	$	$
18.	$	$	$	$
19.	$	$	$	$
20. TOTALS *(sum of lines 16 -19)*	$ 3,000,000.00	$ 3,000,000.00	$ 3,000,000.00	$ 3,000,000.00

SECTION F - OTHER BUDGET INFORMATION	
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23. Remarks	

Section A: Statement of Need

1. Virginia's Vision for the Future: Virginia's Vision for a transformed mental health care system is presented below.

> *Our vision is of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.*

Current Status: This Vision is the product of a strategic planning and restructuring process that began in 2002 when Governor Mark Warner initiated what he described as *"the first stage of a multi-year vision to fundamentally change how mental health, mental retardation and substance abuse services in Virginia are delivered and managed…Our long-term goal is to continue progress on moving the system toward community-based care, so that we can help all Virginians to live in our communities with dignity and independence."* Supporting our Vision of self-determination, empowerment, recovery, resilience and health are foundational values of partnership and collaboration, inclusion and participation, quality, stewardship, and accountability.

In December 2004, for the first time in more than a decade, Governor Warner and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) hosted a statewide Governor's Conference called *"Self-Determination, Empowerment and Recovery: Envision the Possibilities"* to celebrate this new Vision for persons with mental illness, mental retardation or substance use disorders. A. Kathryn Power, Director, Center for Mental Health Services, spoke to 400 leaders from all sectors of Virginia's mental health service system and Governor Warner recognized ten consumer leaders, advocates, and providers with "Living the Vision of Recovery" Awards. The event was a powerful statement of Virginia's broad commitment to our Vision. Virginia will continue to develop new ways to advance our Vision and to recognize and reward individual leaders and programs that exemplify the Vision. The Governor's Conference also solidified and strengthened relationships between consumers, family members, public and private providers, advocacy organizations and local and state agencies, and inspired all stakeholders to continue to collaborate on planning and implementing system transformation.

The restructuring process to date has involved hundreds of mental health consumers, family members and advocates, the Virginia Mental Health Planning Council (MHPC), public and private providers and agencies, state and local officials, and other interested citizens and organizations. The ongoing restructuring process is supported by seven Regional Partnership groups, five statewide Special Population Workgroups, and the Restructuring Policy Advisory Committee that have examined emerging trends; assessed services system strengths, opportunities, challenges, and critical issues; explored opportunities for restructuring the current system; and developed recommendations for an Integrated Strategic Plan which is currently under development (see Objective 2.4, below).

Future Needs: Virginia's Vision has widespread support in the mental health community and has been periodically refined and updated to reflect stakeholder ideas. It has been the inspiration

and guide for many recovery-focused initiatives that have begun to transform and fundamentally change the mental health system in Virginia. Nevertheless, our Vision is largely the product of the public mental health community. While Virginia's efforts to enroll mental health consumers, providers and policy-makers in our Vision have been successful, those efforts need to be expanded to key stakeholders outside the traditional mental health system - to other service agencies (e.g., housing, health, employment, education, social services), payors (e.g., Medicaid and private insurers), academic institutions, faith organizations, and many others. Through the Transformation Working Group and the initiatives to be established under this Mental Health Transformation State Incentive Grant (MHT SIG), the Commonwealth of Virginia will build upon its current restructuring process, broaden the transformation effort, envision greater possibilities, and achieve the Vision articulated above.

2. Goals and Recommendations of *Achieving the Promise: Transforming Mental Health Care in America*: Analysis of Transformation Needs in Virginia.

The following summarizes the current status, gaps and barriers in Virginia relative to the goals and objectives of the President's New Freedom Commission on Mental Health report, *Achieving the Promise: Transforming Mental Health Care in America*.

Goal 1: Americans Understand that Mental Health is Essential to Overall Health

Recommendations

1.1 Advance and implement a [Commonwealth of Virginia] campaign to reduce the stigma of seeking care and a strategy for suicide prevention.

Current Status: Virginia DMHMRSAS has developed and implemented public awareness campaigns related to mental illness. For example, in 1998, DMHMRSAS collaborated with the Mental Health Association of Virginia, the Psychiatric Society of Virginia, Virginias for Mental Health Equity and the State MHMRSAS Board to develop "AIM-Awareness", a public education program combining television spots, celebrity events and the play "My Sister's Sister" with the development and dissemination of a mental health resource guide for consumers and family members. In addition, Virginia has completed a statewide suicide prevention plan entitled, *Suicide Prevention Across the Life Span Plan for the Commonwealth of Virginia*[1], which is based on the *National Strategy for Suicide Prevention: Goals and Objectives for Action*[2]. Virginia's *Plan* incorporates public awareness, education and stigma reduction strategies related to suicide prevention.

Gaps and Barriers: Virginia does not have an organized statewide public education campaign to raise awareness and understanding of mental illness.

1.2 Address mental health with the same urgency as physical health.

Current Status: As indicated above, Virginia has developed a clear vision of a transformed mental health system, and has several initiatives underway to achieve that vision. Virginia's Vision has evolved to include specific recognition and focus on *resilience* and *health*. Virginia recognizes the need to raise awareness of the importance of mental health (including co-occurring substance use disorders) to a level comparable to the level of awareness that exists for physical health. Collaboration is also underway between DMHMRSAS and the Virginia Association of Free Clinics to explore opportunities for further integration of mental health and health awareness.

Gaps and Barriers: As described above, and in Objective 4.4, below, Virginia is developing greater awareness of the need to screen for mental health and co-occurring treatment needs in all areas of healthcare, but these strategies have not been uniformly adopted.

Goal 2: Mental Health Care Is Consumer and Family Driven

Recommendations

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

Current Status: DMHMRSAS is responsible for licensing all mental health treatment providers in Virginia. Licensing requirements include developing, and periodically updating an Individualized Service Plan (ISP) for every consumer receiving services. Licensing regulations require the ISP to address individual needs and preferences, that the ISP is developed in partnership with each consumer, and that the plan is reviewed at least quarterly and updated as necessary.

Gaps and Barriers: Stakeholders involved in the DMHMRSAS restructuring effort recognize that many ISPs and provider treatment practices are not recovery-oriented, and that consumer choices regarding services and supports vary widely as local funding levels often define the array of services that are available.

2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

Current Status: Virginia has made great strides toward achieving this objective. Most recently, as described above, consumers and families have played a major role in the restructuring of Virginia's system of mental health services and in developing and shaping the current Vision for the system of care in Virginia. In 2003, the Virginia Mental Health Planning Council (MHPC) resolved that orienting the mental health system toward recovery (though policy development, education, programs, and advocacy) was its chief priority. In partnership with the MH Planning Council, DMHMRSAS funded the Recovery Education and Creative Healing (REACH) initiative to enable consumers to teach the Wellness Recovery Action Plan (WRAP) to other consumers. This partnership also funded the VOCAL Network, a statewide consumer network for mental illness survivors. Both initiatives are programs of the Virginia Organization of Consumers Asserting Leadership (VOCAL).

Gaps and Barriers: Despite the comparatively high level of consumer involvement in setting the broad direction for the mental health system, and in specific initiatives such as those described above, consumers in Virginia are not routinely involved in public mental health policy-making, planning, service delivery and decision-making at the state, regional or local levels. Less is known about the level of consumer involvement in the private sector mental health system, but it is thought to be similarly low.

2.3 Align relevant Federal programs to improve access and accountability for mental health services.

Current Status: Virginia has taken steps to maximize both federal and state resources that support housing, employment and vocational rehabilitation, criminal and juvenile justice, social security, and education to improve access and accountability.

Supported Housing: Virginia's most recent effort to align effective housing resources is an initiative recommended by the Chronic Homeless Policy Academy and sponsored by the Virginia Inter-Agency Council for the Homeless (VIACH) to create a "housing first" demonstration modeled after the San Francisco "Direct Access to Housing" project as an alternative to revolving homeless episodes and local hospital emergency and inpatient psychiatric stays. Implementation of this initiative continues with state and local support. Another VIACH project merges federal PATH funds with HUD HOME funds to demonstrate outreach and housing first projects for homeless adults with serious mental illness. Governor Warner also proposed rental assistance funds for Olmstead-covered groups in his budget, but the General Assembly did not approve and instead requested another study.

Supported Employment: Virginia was recently awarded a three-year CMS Real Choice Systems Change Grant to help make policy and financing changes, in part, to implement the EBP of supported employment. Virginia's Olmstead plan (described in recommendation 2.4) also includes recommendations to improve vocational rehabilitation and supported employment systems to better meet the needs of mental health consumers. Virginia remains in negotiations with CMS over a proposed Medicaid Buy-In Demonstration Waiver designed to study the longer-term services and supports required for disabled consumers to experience meaningful career advancement.

Criminal and Juvenile Justice: A Forensic Special Population Workgroup is a key component of Virginia's existing restructuring process and has developed consensus recommendations for cross-agency action to improve services for persons with mental illness in the criminal justice system. These include recommendations for policy, program development, training and collaboration. In addition, Virginia's Policy Academy on Chronic Homelessness and its Academy on Prisoner Reentry recently sponsored a joint conference, entitled "Partnerships and Housing: The Keys to Safer Communities", for approximately 150 state and local representatives of housing, criminal justice, and mental health services to review and plan for successful post-incarceration housing and supportive services in two of the states most impacted urban areas. Also, DMHMRSAS, and the Departments of Juvenile Justice (DJJ) and Criminal Justice Services (DCJS) are currently using Juvenile Accountability Incentive Block Grant funds to provide mental health services and case management to juveniles in secure detention facilities who have mental health problems (estimated at 50-75%).

Social Security: Virginia's Departments of Rehabilitative Services (DRS) and Medical Assistance Services (DMAS) have partnered with the Social Security Administration, Benefits Planning and Outreach (BPAO) organizations, and One-Stop Job Centers to provide ongoing training to SSI recipients and their caregivers on 1619(b) and other work incentive programs. DMAS and DMHMRSAS are also planning outreach and training to Medicare recipients, particularly "dual-eligible" persons, on preparing for the new Part D benefits program scheduled to begin January 1, 2006. The Department of Social Services, DMHMRSAS, and VIACH have partnered to fund benefits acquisition specialists in homeless outreach programs to target individuals with mental illness.

Education: The Virginia Human Services Training (VHST) program is a successful model of supported education. VHST is a mental health-education partnership that prepares mental health

consumers to assume roles as providers on PACT teams, in supportive residential programs and other mental health settings. The VHST is co-sponsored by DMHMRSAS, DRS, Piedmont Community College and Region Ten Community Services Board (CSB).

Gaps and Barriers: Virginia's state, regional, and local agencies have increased collaborative efforts to strengthen and maximize each other's resources for the benefit of mental health consumers, but this work is in its infancy. The projects described above, for example, are innovative and successful, but peripheral to their sponsor agencies' primary functions. Virginia has many overlapping studies and planning efforts designed to guide services for Virginian's with mental illness, and as the preliminary inventory of resources demonstrates (see A.3, below), Virginia is using a substantial portion of mainstream funding for services for Virginian's with mental illness. Most of these expenditures, however, are made without any coordinated guidance.

2.4 Create a Comprehensive State Mental Health Plan.
Current Status: As described earlier, Virginia is actively engaged in a statewide restructuring of the mental health care system. In 2005, hundreds of stakeholders from across the Commonwealth, working through the Restructuring Policy Advisory Committee, seven Regional Partnerships, and five Special Populations Workgroups, have provided input into development of an *Integrated Strategic Plan (ISP)* that will outline a framework for and specific actions to transform Virginia's mental health, mental retardation, and substance abuse services system.

The ISP will be completed in Summer 2005 and will include the following seven critical success factors for implementing the Vision of a consumer-driven system of care as well as implementation action steps.

1. Virginia successfully implements a consumer-driven, recovery and resilience-oriented, and person centered system of services and supports.
2. Publicly funded services and supports that meet growing consumer needs are available and accessible across the Commonwealth.
3. Funding for mental health, mental retardation, and substance abuse services and supports sustains quality consumer-focused care, promotes innovation, and assures efficiency and cost-effectiveness.
4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.
5. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.
6. Effective service delivery and utilization management assures that consumers and their families receive services and supports that are appropriate to their individual needs.
7. Mental health, mental retardation, and substance abuse services and supports meet the highest standards of quality and accountability.

In addition, the DMHMRSAS fulfills a statutory responsibility to produce and biennially update a six-year plan for mental health, mental retardation, and substance abuse services. This Comprehensive State Plan (CSP) documents the specific services needs, demographic

characteristics, and special circumstances and risk factors of adults and children and adolescents on waiting lists for community mental health services provided by Virginia's forty community services boards (CSBs, which are the local public mental health service providers). The CSP also provides extensive descriptive information about service utilization trends. It also includes major strategic issues and outlines resource requirements and proposed budget initiatives.

Also, in developing the Community Mental Health Services Performance Partnership Plan, pursuant to PL 102-321 (the CMHS Block Grant), the Department builds on the work of the CSP and other agency planning efforts such as the work of the Child and Family Behavioral Health Policy and Planning Committee, which is tasked in state budget language with the development of an integrated policy and plan for children's behavioral health services across state and local agencies. This committee prepares an annual report to the General Assembly with budget, policy, and legislative recommendations to improve access to children's behavioral health services. These recommendations also are incorporated into the CSP and the CMHS Performance Partnership Plan.

Since 2002, Virginia has also been involved in a cross-agency initiative to respond to the U.S. Supreme Court's Olmstead decision[3]. In 2003, a broadly representative gubernatorial Task Force issued a report with over 200 recommendations that focused on the needs of individuals with physical, sensory, and mental disabilities. To build on the work of the Task Force, Governor Warner also created a Community Integration Oversight Advisory Committee (a gubernatorial advisory commission), and a Community Integration Implementation Team comprised of 18 state agencies that provide or oversee services to individuals with disabilities. Governor Warner also appointed a Director of Community Integration in the Office of the Governor to coordinate the work of Oversight Committee and the Implementation Team and to report annually to the Governor on the status of efforts to improve the quality and coordination of services and supports received by Virginians with disabilities.

Gaps and Barriers: Although representatives from several state agencies, including the state Medicaid agency, have been involved in this process, the ISP lacks the broader cross-agency planning and budgeting required for the Comprehensive Mental Health Plan envisioned in *Achieving the Promise*, Recommendation 2.4, and the MHT SIG. Similarly, the ISP will lack the integrated cross-agency commitment to transformation at the highest levels of state government.

2.5 Protect and enhance the rights of people with mental illnesses.
Current Status: Section 37.1-84.1 of the *Code of Virginia* sets out the rights of individuals receiving services from providers of mental health, substance abuse and mental retardation services and requires providers seeking a DMHMRSAS license (to provide services) to be in compliance with human rights regulations as a condition of licensing. The relevant human rights regulations apply to 982 licensed MH, MR and SA services, delivered by 350 providers at 2168 locations, and affect over 190,000 service recipients. Virginia's "internal" (DMHMRSAS) human rights "infrastructure" to oversee this system includes:

- The State Human Rights Director and Office of Human Rights within DMHMRSAS.
- The State Human Rights Committee, which oversees implementation of the overall human rights program.

- Sixty-five Local Human Rights Committees, which administer various aspects of the human rights program
- Twenty-four advocates, who represent consumers, and work with providers to prevent rights violations

In addition, Virginia established the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services in 2000. The Inspector General reports to the Governor and inspects, monitors and reviews the quality of services in programs operated by DMHMRSAS and other licensed providers.

Virginia's protection and advocacy office under the federal Protection and Advocacy for Individuals with Mental Illness Act (PAIMI) is the Virginia Office of Protection and Advocacy (VOPA). VOPA investigates conditions in state facilities and community settings and advocates for the rights of individuals.

Gaps and Barriers: A balance between Virginia's internal (DMHMRSAS) human rights system and the external review and enforcement powers of the Inspector General and the Office of Protection and Advocacy has only recently been established, and these entities are still developing their respective roles and relationships.

Goal 3: Disparities in Mental Health Services Are Eliminated
Recommendations
3.1 Improve access to quality care that is culturally competent.
Current Status: Virginia's 2005 *Consumer Satisfaction Survey* (MHSIP) revealed that 83.8% of respondents agreed with the statement, "[CSB] staff are sensitive to my cultural background". The 2005 *Parent Perceptions of Services at CSBs* survey (MHSIP) showed that 88.2% of caregivers had positive perceptions of CSB services in the four items which form the "cultural sensitivity" domain.

Gaps and Barriers: Virginia has no other self-assessment data on cultural competency, and no policy or oversight infrastructure to measure cultural competence. Local MHSIP data, as well as subjective perceptions of cultural competency, indicate wide variability across CSBs.

3.2 Improve access to quality care in rural and geographically remote areas.
Current Status: Virginia has installed televideoconferencing capability in each CSB and DMHMRSAS facility to facilitate access, communication, treatment and discharge planning and other efficiencies. In addition, telemedicine technology exists at selected rural mental health providers, as well as Correctional facilities and Universities. One CSB (New River Valley) has purchased and implemented the *Network of Care*® web-based resource and information system for consumers in its rural catchment area.

Gaps and Barriers: Geographic isolation significantly hinders access to mental health services in many rural areas. Many of the most rural areas of Virginia also experience higher rates of poverty, unemployment, substance abuse and suicide. Other problems include lack of public transportation, relatively low local contributions to service delivery, and difficulty recruiting, hiring and retaining qualified staff.

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

Recommendations

4.1 Promote the mental health of young children.

Current Status: In response to stakeholders, DMHMRSAS created a new Office of Child and Family Services in April of 2004 to merge existing DMHMRSAS child and family resources and staff, and to operationalize the priority placed on developing an integrated, seamless system of care for children. Young children, especially those from 0 to seven, are a priority in Virginia. Intervention must occur early in young children's lives to reduce the impact of trauma, violence, disaster, mental illness, substance abuse or family problems. Early detection and treatment results in substantially shorter and less disabling conditions later. Virginia's state Medicaid plan covers targeted case management for young children at risk of serious emotional disturbance. Case managers may identify children who, due to family or other risk factors, need early intervention to reduce the effects of trauma and subsequent emotional disturbances. Virginia's Comprehensive Services Act requires coordination between all children serving agencies in the planning and funding of services. The CSA target population is troubled and at-risk youth.

Gaps and Barriers: Too many Virginia youth are in out-of home placements. In a recent study, 23% of Virginia youth in foster care (2,008 of 8,702 children) appeared to be in custody in order to obtain mental health treatment. In addition, more very young children are in "deep-end", acute intensive and residential services.

4.2 Improve and expand school mental health programs.

Current Status: Virginia is at a significant turning point regarding the services needs of our children. The Office of the Comprehensive Services has initiated data collection to document the multiple mental health diagnoses of the 16,000 children it serves. The Commission on Youth developed a *Collection of Evidence Based Practices of Effective Treatment Modalities for Children and Adolescents.* The DMHMRSAS Child and Adolescent Workgroup identified recommendations to restructure mental health, mental retardation and substance abuse services to improve the behavioral health system of care for children and their families.

Virginia has emphasized development of mental health services in schools because all children attend some type of school, and school is the best setting for identifying children early who may need mental health interventions. For example, Virginia's Medicaid Plan covers therapeutic day treatment services, which is most frequently provided by community services boards (CSBs) in schools. State and local coordination has also been improved to assure that the mental health and school systems work together.

In addition, Virginia's State Incentive Grant for Treatment of Co-Occurring Disorders (COSIG) focuses on developing a standardized screening and assessment protocol for youth and adults with co-occurring mental illness and substance use disorders. The outcome of this effort will ensure that screening for co-occurring disorders in adolescents will be a part of CSB intake procedures (see Objective 4.3, below). Also, Virginia's suicide prevention activity includes initiatives to reduce youth suicide that have been ongoing since 2001. One goal of these efforts is to incorporate mental health screening into the services provided by pediatricians to children during general health care visits. Lastly, DMHMRSAS received $1,000,000 in state funds for

FY 2006 to establish two CSB demonstration sites to model System of Care principles and practices. These sites, when established (beginning July 1, 2005) will serve as prototypes of school-based mental health services (among other services).

Gaps and Barriers: Despite many interagency initiatives, there are too few school-based mental health services for Virginia's youth.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Current Status: The Commonwealth of Virginia is involved in two significant, related efforts to expand comprehensive, coordinated services to consumers with co-occurring mental health and substance abuse disorders.

First, Virginia was awarded a SAMHSA State Incentive Grant for the Treatment of Persons with Co-Occurring Substance Related and Mental Health Disorders (COSIG) in 2004. The COSIG initiative will standardize screening and assessment of persons with co-occurring disorders and ensure they are linked with appropriate treatment. In addition, it will include clinician training and data system development to support identification and tracking of co-occurring disorders. While several CSBs have initiated fully integrated services for persons with co-occurring disorders, the COSIG-funded activities will be piloted at eleven community services boards (CSBs) serving central and southern Virginia. In the latter years of the grant, this approach will be expanded statewide, with the overall goal to develop a comprehensive, coordinated and integrated system of care for adults and youth with co-occurring disorders that will improve recovery outcomes for consumers throughout Virginia.

Secondly, Virginia was invited to participate in the 2nd National Policy Academy on Co-occurring Mental Health and Substance Abuse Disorders in January 2005. State MH, SA and Medicaid officials, consumers and providers crated an Action Plan for Virginia that prioritizes action in five key areas, as follows:

1. Affirming/reaffirming Virginia's commitment to vision-driven system change and integration of services;
2. Maximizing funding resources to serve co-occurring disorders (COD), including Medicaid;
3. Strengthening the workforce to address COD;
4. Optimizing service delivery to COD clients, including capacity-building; and,
5. Optimizing existing data systems, and developing new systems, to identify need, and track service provision, consumer outcomes and costs within and across systems of care.

Gaps and Barriers: While the COD Policy Academy and the COSIG grant provide system change mechanisms that will expand the use of recovery-oriented evidence-based and consensus best practices, there is insufficient infrastructure and guidance to promote a standard of care for co-occurring disorders across the state system. Consumers and other stakeholders should be more involved in the COSIG effort.

4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Current Status: Early identification and intervention enhances the likelihood of positive outcomes for adults and children with mental illnesses. DMHMRSAS has developed an early intervention model for Screening, Assessment, Referral and Brief Intervention (SARBI) for mental health and substance use disorders to help physicians, nurses, social workers, psychologists, health educators, and outreach workers identify and intervene with individuals suffering with these disorders. As part of this initiative, DMHMRSAS developed a *Substance Abuse Tool Box for Primary Care Providers*[4]. The model includes standardized screening protocols for adolescents and adults, and includes specific screening for exposure to trauma, terror, abuse or disaster. The model enables health care providers to determine whether individuals would benefit from brief intervention or referral for a comprehensive assessment and specialized treatment[5].

DMHMRSAS has also initiated discussions with the Virginia Association of Free Clinics to begin to address the needs of shared consumers with mental illness, and to encourage collaboration and mutual support for issues of common interest. The Virginia PATH program is also working to forge collaborations between the homeless mental health outreach workers and primary care environments that include Free Clinics and staff housed at a Health Care for the Homeless Clinic. The Virginia Department of Housing and Community Development provides funding for staff to provide mental health and abuse assessments of children living in shelters, and to assist children in accessing early intervention services to address their needs. Additionally, DMHMRSAS is working with hospitals and emergency rooms to facilitate a more effective and efficient method of accomplishing medical screening for persons in psychiatric crises.

Gaps and Barriers: Although training has taken place, lack of funding has prevented Virginia's SARBI model from being implemented. In addition, the lack of integration of medical and psychiatric services has impeded timely access for consumers to acute mental health services. This has, in turn, increases demands on emergency rooms, law enforcement, jails, and communities in general.

Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated

Recommendations

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

Current Status: DMHMRSAS is committed to expanding understanding of mental illness through public and private research partnerships. The Department has access to a large mental health cohort and periodically conducts joint research with the University of Virginia, Virginia Commonwealth University/ Medical College and other medical schools in support of common research goals.

Gaps and Barriers: The Department and participating universities have no integrated research plan to ensure that critical research issues are addressed on an ongoing basis. Potential research efforts utilizing the experience and expertise of Virginia's universities will be facilitated by resources made available by the grant, to actively engage public and private university research partners in identifying critical research issues relating to evaluation, treatment and prevention

with this cohort, to identify barriers to such research, and to develop strategies for overcoming these barriers.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create public-private partnership to guide their implementation.

Current Status: Virginia has achieved significant progress in supporting recovery-oriented evidence-based (EBPs) and consensus best practices. EBPs currently available in Virginia include supported housing, supported employment, assertive community treatment, illness management and recovery, therapeutic foster care, functional family therapy, Multi-Systemic Therapy, integrated treatment for co-occurring disorders (MH/SA), and new generation medications. At the December 2004 Governors Conference and the May 2005 conference of the Virginia Association of Community Services Boards (VACSB), Virginia's commitment to use of EBPs was highlighted as model programs were presented and honored.

Stakeholders recognize the importance of EBPs and have strived to support and sustain innovation. One community recently initiated a mental health court, and another a Crisis Intervention Team for persons involved in the criminal justice system. DMHMRSAS and the MH Planning Council have funded an Illness Management and Recovery EBP initiative utilizing the Wellness Recovery Action Plan (WRAP) approach. Fifteen Assertive Community Treatment programs (PACT) have been developed by community services boards, and four of these programs have been awarded funding by DMHMRSAS to function as demonstration and training sites for other providers interested in developing or enhancing PACT services. Each demonstration/training site will be able to provide program consultation and on-site experiential training to direct care and management staff. Outcome data from the PACT initiatives have shown dramatic reductions in hospital usage, increased stability in living situations for individuals, and reduced involvement with criminal justice agencies.

Most individuals with mental illness in Virginia have access to "new generation" medications through their private insurers, Medicaid or a centralized Aftercare Pharmacy operated by DMHMRSAS for persons with mental illness seen through CSBs. The Virginia DMHMRSAS supports family psycho-education through its contracts with NAMI-VA and the Southwest Virginia Behavioral Health Board. Multi-Systemic Therapy for adolescents is also offered at several other CSBs. Twelve science-based prevention programs now operate for families, including services for new parents, for Head Start children and their parents, and families with children and adolescents. Despite these efforts, most individuals receiving services in Virginia's mental health system, however, do not have consistent access to such evidence-based or consensus best-practice services.

Virginia stakeholders recognize that *"evidence-based [practice] is the integration of the best research evidence with clinical expertise and patient values"*[6]. This means that evidence-based and consensus best practices must be recovery-oriented and focused on recovery outcomes, not just on outcomes that may be positive for the system (e.g., reductions in hospital use, cost). Virginia consumers and providers continue to work together to develop, disseminate, and support a core of evidence-based and consensus best-practice service models, and uniform clinical practices, that will provide consistency of services throughout the state and promote positive outcomes and recovery for persons with mental illness. A core of evidence-based practices for

services across the state will also ensure informed choices for consumers and families, as well as ease of movement from one service area to another.

Gaps and Barriers: There is inconsistent understanding of evidence- based and consensus best practices, and further integration of EBPs with recovery outcomes is needed. Mainstream funding (Medicaid and state funds) does not explicitly support EBPs or recovery-oriented practice, and there are no incentives or rewards for providing effective services that help people recover from mental illness. The array of services available to consumers and families is highly variable from one locality to another.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

Current Status: DMHMRSAS recently polled community services board mental health directors regarding their priorities among the six goals and nineteen objectives of the President's New Freedom Commission report. The most important priority for this group was to improve and expand the workforce providing recovery-oriented evidence-based practices. Many public and private providers (including peer providers) deliver excellent services that are highly regarded by the individuals who use them. Many of these were recognized at the December 2004 Governor's Conference and the May 2005 VACSB conference, as described above.

Gaps and Barriers: Access to evidence-based and consensus best practice mental health service is very inconsistent statewide. Many providers are not trained in these interventions, and the funding, licensing and other infrastructure of the service system does not include incentives for providing EBPs.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Current Status: Research regarding key issues in mental health is needed to effect policy changes at the state and federal levels, to support treatment approaches that lead to recovery, and ensure that mental health consumers have access to a range of services and supports. Virginia has made progress by establishing infrastructure and initiating research in two of the four understudied areas.

- **Psychotropic medications:** DMHMRSAS is developing a pharmacy data warehouse to provide information about psychiatric medication utilization in inpatient and outpatient settings in collaboration with the Department of Medical Assistance Services. Development of the Behavioral Quality Indicator program will provide information on medication usage and provider/prescriber practice patterns.
- **Acute care:** DMHMRSAS is examining the consumer characteristics (e.g., diagnostic composition, pharmacological practice, etc.) that result in referrals to inpatient acute care services to assure the best referral methods. A collaborative relationship between the DMHMRSAS and the Virginia Hospital and Healthcare Association (VHHA) is promoting effective linkages at the local and regional level within the Commonwealth.

Gaps and Barriers: Virginia has a limited mental health research agenda. Existing programs must be expanded to include research related to parity for mental health services and trauma

informed care, and the results must be used by legislators and policy makers to effect state and federal policy changes.

Goal 6: Technology Is Used to Access Mental Health Care and Information

Recommendations

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

Current Status: Virginia has strongly supported the development and expansion of telemedicine in the delivery of services to Virginians with mental illness. Telepsychiatry is currently being utilized to provide direct care to clients in rural areas and to assure continuity of care between state facilities, community treatment providers, local judiciary and law enforcement personnel in the admission and discharge planning processes. During the past three years DMHMRSAS has expanded its video teleconferencing capacities to all CSBs and state facilities using ISDN lines and the Polycom Viewstation 512 Multipoint system. Also, four Virginia CSBs have established the *Network of Care*® system in their communities. *Network of Care*® is a web-based resource that links information on mental illness, services, supports and resources in a given community, and empowers consumers and families to pursue their preferred services and supports themselves.

Gaps and Barriers: Greater coordination among state agencies is necessary to expand the use of this technology, ensure that technology is compatible across agencies, and to educate agencies and the public on the availability and effectiveness of these means of communication. Regarding telemedicine, technical assistance and cross-agency networking to participants is also needed, as well as supportive reimbursement.

6.2 Develop and implement integrated electronic health record and personal health information systems.

Current Status: Planning District One CSB in rural Southwest Virginia has implemented an electronic medical record at all its service sites. Many Virginia providers wish to expand this technology. The 2005 General Assembly made available $50,000 to the Virginia Department of Health to pilot test an integrated electronic health record at a local hospital, to evaluate the potential technology and to serve as the basis for future planning.

Gaps and Barriers: More extensive, coordinated planning is necessary with all stakeholders, and especially consumers and providers, to ensure that advances in the use of electronic medical records are consistent with the recovery vision and protective of human rights.

3. Current Stakeholders and Preliminary Inventory of Resources

The following state agencies will be on the Transformation Working Group: Department of Corrections (DOC), Department of Juvenile Justice (DJJ), Department of Social Services (DSS), Department of Rehabilitative Services (DRS), Office of the Inspector General (OIG), Department of Housing and Community Development (DHCD), and Department of Medical Assistance Services (DMAS). Agencies were surveyed to determine if they provided any promotion, prevention, early intervention, treatment, or recovery support services or functions. They were also asked a number of questions about their resources. Several agencies did not include their local affiliates in their data submission so the budget and FTE numbers are most

likely an underestimate. This will be clarified in the comprehensive needs assessment to be developed as part of the grant.

Regarding funding, almost 12% of the total budgets of these eight agencies are earmarked for mental health related activities and 40% of FTEs are dedicated to mental health activities. Excluding DMHMRSAS, less than 1% of FTEs in the remaining agencies are dedicated to mental health activities and 10% of the total agency budgets are dedicated to mental health.

Agency	Total Budget	MH Budget	Total FTEs	MH FTEs
DHCD	$6,335,454	$1,790,240	132	*
DJJ	$196,224,549.00	$5,000,000.00	11	12
DMAS	$3,745,873,299	$662,004,837	317	16
DOC	$849,479,999	*	12576	154
DRS	$127,600,000	$750,000	700	12
DSS	$1,655,194,749.00	*	8573	*
MHMRSAS	$780,601,787	$223,618,447	21824	17503
OIG	$400,000	$400,000	3	3
TOTAL	$7,361,709,837	$893,563,524	44004	17700

* While these agencies provide services to individuals with mental health issues, they do not have any funding or FTEs specifically dedicated to mental health related activities.

Below is data related to other resources and strengths that each agency reported. It is noteworthy that five agencies reported that they had policy(s) related to mental health, which shows some early commitment towards mental health transformation. About half the agencies have video teleconferencing. Six agencies reported having policies or initiatives that address cultural competence and six reported policies or initiatives addressing trauma.

Agency	MH Policy	MH Facility	Vehicles to Transport Consumers	Video Teleconference	Electronic Record	Cultural Competency Policy	Trauma Policy
DOC	Y	Y	Y	Y	Y	Y	Y
MHMRSAS	Y	Y	Y	Y		Y	Y
DJJ	Y	Y	Y	Y	Y	Y	Y
DSS						Y	Y
DRS	Y		Y		Y	Y	Y
OIG				Y			Y
DHCD							
DMAS	Y					Y	

The tables below reflect information on the types of services that agencies provide. Only one agency reported engaging in promotion activities and this was only for children and adolescents. Six agencies reported prevention activities with the most common age group served being children and adolescents. Seven agencies reported providing treatment for individuals with mental health. Four agencies reported engaging in any recovery-related activities.

	Promotion Activities			Prevention			Intervention		
Agency	0-17	18-64	65+	0-17	18-64	65+	0-17	18-64	65+
DOC					Y	Y		Y	Y

MHMRSAS				Y			Y		
DJJ				Y	Y		Y	Y	
DSS				Y	Y		Y	Y	Y
DRS									
OIG									
DHCD				Y	Y	Y	Y		
DMAS	Y			Y			Y	Y	Y

	Treatment			Recovery		
Agency	**0-17**	**18-64**	**65+**	**0-17**	**18-64**	**65+**
DOC		Y	Y			
MHMRSAS	Y	Y	Y	Y	Y	Y
DJJ	Y	Y		Y	Y	
DSS	Y	Y				
DRS					Y	Y
OIG						
DHCD				Y	Y	Y
DMAS	Y	Y	Y	Y	Y	Y

4. Demographics of the Commonwealth of Virginia, Prevalence of Mental Illness, Risk and Protective Factors.

The following are demographic data, risk and protective factors describing Virginia[7]:

- Virginia's population in 2000 was 7,078,515. It is estimated to have increased 4.3% by July 1, 2003, which is slightly higher than the percent increase in the USA.
- The NASMHPD Research Institute NRI has estimated the prevalence of SMI and SED in Virginia to be 5.4% and 7%, respectively.
- Virginia's suicide rate is ranked 31st highest in the nation at 10.8 per 100,000 persons.
- Acculturation related stress has been linked to suicide and about 11% of the population speaks a language other than English at home.
- Racial distribution in 2000 was as follows: 72.3% White, 19.6% Black, .3% American Indian and Alaskan Native, 3.7% Asian, .1% Native Hawaiian and Other Pacific Islanders, 2% Other, and 2% reporting more than one race.
- About 17% of non-elderly non-Latino African-Americans and non-elderly non-Latino Asians are uninsured, which limits their access to care and is a risk factor for suicide.
- Almost 5% of the population identified themselves as being of Hispanic Origin.
- About 34% of non-elderly persons reporting to be of Hispanic Origin are uninsured.
- The median household income in 1999 was $46,677 while the per capita income was $23,975.
- Almost 10% of the population is below the poverty level. This group is at increased risk for suicide, serous mental illness and serious emotional disturbance.
- Sixteen percent of the population reported being disabled, another risk factor for suicide.
- There are almost 179 persons per square mile. Risk factors for suicide include living in a rural area and the highest rates in Virginia are reported in these areas.

- Unemployment is also linked to suicide. The unemployment rate in Virginia in March 2005 was 3.4%, which is among the lowest in the nation and can be seen as a protective factor. However, isolated rural areas reported rates as high as 10.6%.

Section B: Proposed Approach: Organizational Structure

1. Organization of Government and Services: Virginia government includes Executive, Legislative and Judicial branches. Governor Mark Warner's office includes his Chief of Staff and eleven Cabinet Secretaries who administer state agencies. The Secretaries of Health and Human Resources, Public Safety and Education administer the majority of agencies whose services may affect persons with mental illness and their families. The principal agencies among these are represented on the Transformation Working Group.

The primary providers of public community mental health services are the 40 community services boards (CSBs) or behavioral health authorities, which are local government entities that vary considerably in per capita funding, geography, services, populations served, political jurisdictions served, and organizational structure. Public inpatient services are provided through state DMHMRSAS hospitals and local community hospitals under contract with CSBs. These services are funded by federal, state and local funds granted directly to these agencies through DMHMRSAS and local government, and also through direct payments from third-party payors such as Medicaid.

The DMHMRSAS also provides direct funding to six consumer-run peer service providers, as well as the Consumer Empowerment and Leadership Training program; the Virginia Human Service Training program (see objective 2.3, Current Status Education, above); and a family education program provided by NAMI-VA. DMHMRSAS supports the Virginia Organization of Consumers Asserting Leadership (VOCAL), an umbrella organization of mental health consumers that provides technical and financial support to peer providers, as well as teaching Wellness Recovery Action Plan to consumers through the Recovery Education and Creative Healing (REACH) project. VOCAL is also developing the statewide consumer network.

2. Commitment by the Governor to Transformation: As described above (see Section A, Vision) Governor Warner and Secretary of Health and Human Resources Woods have initiated and supported the major restructuring of public mental health services that has been underway since 2002 in Virginia. They have been outspoken in their support of transformation, and have demonstrated through numerous initiatives already underway that they will continue to pursue the Vision for Virginia's mental health system.

3. Gubernatorial Election, November 2005: Virginia will hold a statewide election for Governor, Lieutenant Governor, and Attorney General in November 2005. Virginia's Governor is prohibited from serving successive terms, so a new Governor and other elected officials will be taking office in January 2006. The presumed candidates for Governor are the current Lt. Governor, Tim Kaine (D), and the former Attorney General, Jerry Kilgore (R). Cabinet Secretaries, agency heads and certain other senior executives serve at the pleasure of the Governor. Historically, gubernatorial elections precipitate widespread leadership changes throughout the Executive branch. Some degree of change is expected in January 2006, when the

new Governor takes office. Both candidates have the authority to appoint their own leadership if elected, and changes to the Transformation Working Group (TWG) are anticipated.

4. Transformation Working Group Membership:
The Chairperson of the Transformation Working Group will be the current Commissioner of DMHMRSAS, James S. Reinhard, M.D. The Virginia Mental Health Transformation Working Group will include the following voting members:

- Transformation Work Group Chair, James S. Reinhard, M.D., Commissioner, Department of MH, MR and SA Services
- Inspector General (ex officio)
- Commissioner, Department of Rehabilitative Services (ex officio)
- Commissioner, Department of Social Services (ex officio)
- Director, Department of Medical Assistance Services (ex officio)
- Director, Department of Corrections (ex officio)
- Director, Department of Juvenile Justice (ex officio)
- Chair, State Executive Council (Comprehensive Services for At-Risk Youth) (ex officio)
- Director, Department of Housing and Community Development (ex officio)
- Nine adult mental health consumer representatives (three appointed from the Mental Health Planning Council, three from the VOCAL Network, three at-large members)
- Five youth mental health consumers or parents
- Five family members and mental health advocates (including two from NAMI-VA, two from Mental Health Association of Virginia, one at-large member)
- Seven Restructuring Partnership Planning representatives (one from each region)
- President, Virginia Hospital and Healthcare Association (ex officio)
- Chair of Psychiatry at either University of Va., VCU-Medical College of Virginia, or Eastern Va. Medical School

The above members of the Transformation Working Group (TWG) are the primary agencies and stakeholders of the cross agency, public-private, comprehensive transformation of the mental health system that is envisioned by the President's New Freedom Commission. The makeup of the TWG reflects a strong commitment to maintain, strengthen and utilize the partnerships and processes already established through Virginia's current Restructuring effort to develop and implement the Comprehensive Mental Health Plan. Agencies, organizations and stakeholders not represented on the TWG will be fully involved in the transformation process through the development of the Comprehensive Mental Health Plan (as described in Section C.6, below) and related initiatives.

5. Transformation Working Group Development: Since 2002, Virginia has been engaged in a major restructuring of the mental health system that has included active participation of many of the above TWG members or their agency staff. Nevertheless, the proposed members have not undertaken the intensive cross-agency planning, collaborative problem solving, joint policy and program development, and overall change that is contemplated by the MHT SIG initiative. To address this, Virginia intends to invest $75,000 of MHT SIG funds in Year 1 (and $50,000 per year thereafter) to develop and sustain the leadership, teamwork and other necessary attributes that will be enable the TWG, and key stakeholders and staff to successfully engineer true transformation of the mental health system. Such training and development is available through

the Weldon Cooper Center for Public Service at the University of Virginia. The Weldon Cooper Center is the national leader in training public service executives, managers and others in federal, state and local government to develop and maintain high performance organizations, and has worked with DMHMRSAS senior leadership in that capacity. The TWG and the Weldon Cooper Center will ensure that training is tailored to the specific needs of the TWG membership.

6. Diversity: Many agency members of the TWG will be *ex officio* participants, but all other members will be appointed to reflect the geographic, ethnic and cultural diversity of Virginia. Virginia will use $60,000 of MHT SIG funds in the first year to contract with NASMHPD Research Institute to engage in assessment and planning to improve cultural competence of Virginia's service system. This planning will be reflected in the operations of the TWG and the transformation process.

7. Letters of Commitment: Letters of commitment from proposed Transformation Working Group members and others are attached in Appendix I.

8. Role of Virginia Mental Health Planning Council: For many years, the Virginia Mental Health Planning Council (MHPC) has been a leading force in focusing the state on a vision of recovery for persons with mental illness. The MHPC has also been a major, leading partner in developing and sustaining many current recovery-focused initiatives. In 2003, the Council decided that educating stakeholders about recovery and pushing providers and payors toward recovery-oriented services and supports was to be the Council's top priority. Council members have been closely involved in the state-level restructuring process to date, but involvement at the regional and local level of consumers, family members and agency members of the MHPC has been widely inconsistent across Virginia, with some areas having very little consumer and family member involvement.

MHPC members will be actively involved in the transformation process through the TWG, where the Council will occupy three seats. The Council will also complete a review of the Comprehensive Mental Health Plan prior to completion. A strong letter of support from the Council President, Ray Bridge, is attached at Appendix I.

Section C: Proposed Approach: Strategy

1. Consumer and Family Involvement in Preparation of Proposal, and in the Comprehensive Mental Health Plan:

The Mental Health Planning Council and the Virginia Organization of Consumers Asserting Leadership were each involved with DMHMRSAS in extensive, intensive discussions about this MHT SIG application during April and May. The application has been modified to reflect evolving consensus and suggestions from consumers and family members. Although there are still areas requiring further discussion and consensus building, consumers and family members, the MHPC, VOCAL and others strongly endorse this application, as evidenced by their letters of support (Appendix I). In addition, the Restructuring Policy Advisory Committee and members of the Virginia Association of CSBs participated in similar discussions of the proposal.

From a broader perspective, this grant application is the culmination of three years of consensus building and planning for restructuring Virginia's mental health system. The following primary

planning bodies have participated in these efforts, and the number and percentage of consumer and family advocate members in each group is displayed.

Planning Group	Members	Cons/Fam	% C/F
Mental Health Planning Council	37	22	59
Restructuring Policy Advisory Committee	84	15	18
Child/Family Behavioral Health Committee	35	5	14
Forensic Special Population Workgroup	18	2	11
Substance Abuse Special Population Workgroup	12	0	0
Geriatric Services Special Population Workgroup	20	0	0
Child/Adolescent Special Population Workgroup	43	6	14
Regional Partnership – Region 1	23	6	26
Regional Partnership – Region 2 (MH Workgroup)	34	2	6
Reg. 2 (MR/MI Workgroup)	23	3	13
Reg. 2 (Psychiatric Hospitals Workgroup)	27	1	4
Reg. 2 (Structural Workgroup)	12	1	8
Regional Partnership – Region 3	12	2	17
Regional Partnership – Region 4	21	3	14
Regional Partnership – Region 5	NA	NA	NA
Regional Partnership – Region 6	4	0	0
Regional Partnership – Region 7	10	4	40
Total Planning Participants (some duplication)	**415**	**72**	**17**

As the table above shows, consumer and family involvement in these longer-term planning efforts has been uneven and disappointing overall. Virginia intends to utilize a $100,000 per year of MHTSIG funds to ensure a high level of participation of consumers (including youth) and family members by providing stipends to help defray their costs. Virginia will also utilize $125,000 of MHTSIG funds to expand consumer training and preparation through the Consumer Empowerment and Leadership Training program (CELT), and will add $50,000 in annual funding to support an Executive Director for VOCAL and $50,000 in annual funding to the Recovery Education and Creative Healing (REACH) program (CELT and REACH are described below, see Section B, Objective 5.3).

The TWG will include standing members from the Virginia Mental Health Planning Council (MHPC), the Virginia Organization of Consumers Asserting Leadership (VOCAL), the Mental Health Association of Virginia (MHAV), the National Alliance for the Mentally Ill of Virginia (NAMI-VA), and other at-large members. In addition, because Virginia will use the existing regional Restructuring Planning Partnerships and existing restructuring workgroups to develop and implement the Comprehensive MH Plan, Virginia will require each existing Restructuring Partnership and workgroup to include and support consumer and family representatives to help develop the Comprehensive MH Plan and serve as liaisons to and for local consumer and family groups.

2. Interface Between Chairperson and Governor, and Chairperson and Working Group: The Transformation Working Group Chair will be appointed by the Governor pursuant to an Executive Order issued to create the Transformation Working Group and the positions of Chair and staff. The Executive Order will describe the duties of the Chair and staff, and the membership and purpose of the Transformation Working Group. The Chair will report to the Governor, but will not have policy or budget authority over Cabinet Secretaries or the agencies within Secretariats, except as may be specified in the Executive Order. TWG staff will be supervised by the Chair.

3. Ensuring That Transformation Occurs:
The Executive Order establishing the TWG will require that a "Transformation Charter Agreement" be developed which will articulate a common vision (to be developed by the TWG), the purpose and goals of the transformation process and the mutual commitment to transformation that each member (and their respective agencies) must make. Each member will sign the "Transformation Charter Agreement" as a declaration of his or her support for the vision and for transformation. The TWG will review the "Transformation Charter Agreement" every six months from the date of execution. Each review will include an evaluation of the role and accomplishments of each executive branch member of the TWG, and each respective agency represented on the TWG, in supporting and actualizing the transformation process, both within their respective agencies, and outside their traditional agency boundaries. The TWG will make and disseminate a report describing the results of each 6-month review, and will submit that report to the Governor and the Cabinet, and make the report available to the public through the websites of the Commonwealth of Virginia, the Governor's Office, the Secretariats and the agencies. In this way, each member of the TWG, and each member agency, will not only be responsible and accountable for transformation within their own agencies and affiliated systems, but will also be responsible for ensuring the success of other transformation partners, and of the transformation process as a whole.

4. Needs Assessment Strategy and Inventory of Resources:
Virginia will utilize $35,000 of MHT SIG funds in the first year to contract with the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI) to complete a comprehensive inventory in order to understand which clients are shared between agencies and to use the results to develop the Comprehensive Mental Health Plan. Through its current Other State Agency (OSA) project, the NRI has extensive experience working with state mental health agencies to develop such inventories. The MHT SIG will utilize a protocol developed by the NRI for the OSA project to identify mental health services across the major state government service providers. It is currently being tested in 10 states to document the numbers of persons receiving mental health services, describe the services provided and estimate any overlaps, and to document the expenditures of OSAs for mental health services.

Once the inventory of resources has been completed, several potential initiatives will be planned to use information systems to assist in transformation, such as developing procedures to share client data between corrections and mental health to identify when persons from the mental health system enter prison and to immediately share histories of medications and mental health treatments; using integrated data between mental health, Medicaid, and other human service agencies to assess the cost-offsets to state government of providing early mental health and substance abuse treatment; and routinely sharing client information between OSAs to improve services quality and assess the progress and impact of transformation. Virginia will utilize $125,000 of MHTSIG funds annually to contract for, purchase or develop information technology enhancements that will support these uses of data as well as the transformation process.

5. Development of the Comprehensive Mental Health Plan
The initial year of Virginia's mental health transformation planning will be focused on developing a sustainable foundation for effective cross-agency transformation activities that are

necessary to successfully implement the vision of a consumer-driven, recovery-focused system of services and supports in Virginia. This work will utilize the existing Restructuring infrastructure (i.e., Regional Partnerships, Special Population workgroups, Restructuring Policy Advisory Committee, etc.) to build upon the current initiative already underway to extend the transformation focus. The present focus of the restructuring process in Virginia is on the DMHMRSAS *Integrated Strategic Plan*, and the Governor's interagency Community Integration (Olmstead) implementation planning process.

In the first MHT SIG grant year, the TWG will establish, guide, and oversee the development of Virginia's Comprehensive Mental Health Plan. First year plan development activities will focus on:

- Establishing a cross-agency shared vision for MH services in Virginia;
- Aligning services, policies and practices, financing, and operational incentives with the vision and the goals of the New Freedom Commission report;
- Enhancing evidence-based and consensus best practices service capacity with respect to housing, employment, education, health, and criminal justice;
- Enhancing cross-agency coordination of policy, budget, and planning functions to support the goals of the New Freedom Commission report.

The TWG will direct and participate in an ongoing process that will broaden all Virginian's collective understanding about the effects of mental illness on individuals, their families, and Virginia communities in general. Also, as described in Section B.5, above, Virginia will invest $75,000 of MHT SIG funds in Year 1 (and $50,000 per year thereafter) to develop and sustain the TWG's capacity to successfully manage large-scale transformation.

Other learning areas will include self-determination and recovery, emerging trends and practices, and new technologies. TWG members will meet with consumers and family members to understand their experiences and expectations for a transformed system of mental health services. Members will also learn from providers about system strengths, challenges and expectations for the future. TWG members will hear from national experts and visit model programs. Through this process the TWG members will develop a common understanding of (a) mental illness and recovery, (b) the roles they (and their respective organizations) will play in transforming the mental health system, and (c) the actions Virginia (through the TWG members) must take to ensure transformation.

As described in Section C.3., the TWG's and Virginia's commitment to transformation will be embodied in the "Transformation Charter Agreement", which will provide strong incentives for collaboration and action, ensuring mutual success and accountability for real transformation.

During the first quarter after Virginia's receipt of the MHT-SIG grant, the TWG will begin a "visioning" process that will start with the restructuring Vision of the DMHMRSAS *Integrated Strategic Plan* (see Section A.1.), and expands that Vision to encompass a cross-agency orientation. The TWG will provide multiple opportunities for stakeholders, including consumers, family members, advocates, CSB and state facility staff, other public agency and

private providers, and other interested citizens to contribute to this visioning process through regional focus groups, forums and other avenues.

The TWG also will ensure that the Comprehensive Mental Health Plan reflects broad-based input from representatives of different cultures, including rural and other underserved communities, ethnic minorities, and other special population groups. As described below (see Objective 3.2, Proposed Activity), Virginia will utilize $60,000 of MHT SIG funds during the first grant year to contract with NRI to develop a culturally competent approach.

To provide a foundation for addressing the goals of the New Freedom Commission report, the TWG will also complete the comprehensive cross-agency needs assessment and resource inventory (see Section C.5, above). These data will help determine the extent to which each agency or Secretariat is currently implementing the shared vision, and what gaps or barriers might be hindering that effort.

Virginia plans to invest $160,000 of MHT SIG funds in Year 1 (declining thereafter) in specialized studies, project planning, and other tasks or deliverables to support the Comprehensive Mental Health Plan development process described above. These resources are shown as "Contracted Project Specialists" in the budget, and may be used to hire temporary contract staff, to contract for project deliverables, TWG training events or other similar purposes.

The TWG will provide leadership to and direct the overall transformation planning effort. The TWG members will join and collaborate with existing transformation activities initiated through the DMHMRSAS restructuring process and the *Integrated Strategic Plan* (e.g., the Regional Partnerships, the Child and Adolescent, Geriatric, and Forensics Special Populations Workgroups), the Mental Health Planning Council, and the Community Integration Oversight Advisory Committee.

The Chair and members will routinely meet with consumers, families, advocacy organizations, local public and private providers, local governments, and other interested citizens across the Commonwealth to ensure that these voices are heard and to "enroll" these stakeholders in the vision and transformation process. The Chair and members will similarly meet regularly with state and local agency heads, their boards and senior leadership to "connect" the transformation vision and planning process to their agencies and the individuals they serve. The TWG will also maintain liaisons with Virginia media to ensure that the general public is apprised of the transformation planning effort.

Virginia proposes to fund the salaries of the TWG Chair, a Chief of Staff, two Transformation Specialists, two Evaluation Specialists and an Executive Assistant to lead and provide direct support to the TWG (see budget). These staff will coordinate the transformation effort and will manage the day-to-day Plan development activities. Staff will work with restructuring leaders and agency staff to pull together the different pieces of the Plan for the TWG.

The Transformation Working Group will compile semi-annual progress reports for submission to the Governor and Cabinet secretaries. These status reports will be used to identify issues and solutions, describe implementation progress, and refine the Comprehensive Mental Health Plan.

They also will be posted on the websites of the Commonwealth of Virginia, the Governor's Office, the Secretariats and the agencies.

The TWG will compile an exposure draft of the Comprehensive Mental Health Plan, which will undergo extensive public review and comment. The TWG will conduct regional public meetings to obtain feedback on the draft plan and will work with the agencies and advocacy groups to use their processes to educate people about the draft plan and to publicize the public comment period. The TWG will present the draft Plan to key legislative committees and their staff, including the Joint Commission on Health Care (and its Behavioral Health Subcommittee), the Senate Finance Committee, and the House Appropriations Committee. Upon completion of the public review process, the TWG will revise the Plan to reflect feedback and transmit the final draft to the Secretariats and agency heads with a request that each Secretary, agency head, and state board chair endorse the plan. Once endorsements are received, the Comprehensive Mental Health Plan will be transmitted to the Governor. Concurrently, the plan will be provided to CMHS for its approval.

6. Strategy for linking MHT-SIG and other grants and resources

As shown above (Section A.3.) almost $900 million is expended in Virginia for mental health treatment and related services and functions (12% of total expenditures) by key transformation group member agencies with a workforce of almost 18,000 full time equivalent workers (40% of total FTEs). Almost all of these funds, however, go towards providing or supporting traditional mental health services or other supports to individuals with mental illness (i.e., such as homeless shelter services funded by DHCD). The federal funds shown below are currently being used by DMHMRSAS to help transform Virginia's mental health system and achieve the goals and recommendations of the President's New Freedom Commission on Mental Health. If only 1.3% of the $900 million in mental health related funds was redirected to a transformation leverage fund, the fund would, in effect, double the identifiable federal resources currently utilized by DMHMRSAS for mental health systems transformation.

DMHMRSAS Federal Funding Source	Annual Federal $ Amount	One-Time $ Amount	Identified Transformation Component	MHT Goals and Recommendation #
Real Choice Systems Change Grant - M.H. Systems Transformation- CMS		300,000	280,000	2.2 5.2, 5.3
Early Intervention	10,398,234		1,097,700	1.2 4.1, 4.2
Mental Health Block Grant	10,976,710		1,089,953	1.1, 2.2, 2.3, 2.4 2.5, 3.1, 3.2, 4.1 4.2, 5.3, 5.4, 6.1
SAPT Block Grant – Prevention	8,190,854		8,190,854	4.1
Projects for Assistance in Transition from Homelessness (PATH)	1,061,000		444,650	1.2, 2.1 2.3, 3.1
Juvenile Accountability Incentive Block Grant (JAIBG)	465,660		465,660	4.1
State Incentive Grant for Co-Occurring Disorders (COSIG)	1,100,000		600,000	4.3 4.4
TOTALS	32,192,458	300,000	12,168,817	

These transformation-related components of existing and future federal grants to DMHMRSAS will be coordinated through the TWG to leverage a greater share of state controlled funds to care for and support Virginians with mental illness in order to ensure that all participating entities

understand, support, and ultimately achieve the New Freedom Commission goals for which they are targeted. As the TWG completes the inventory of resources described above, it will develop mechanisms to leverage additional system transformation funds and braid all of the available various resources together to maximize Virginia's capacity to achieve transformation.

The MHTSIG grant will be specifically utilized to leverage the resources described in Section A.3 to implement the recommendations of *Achieving the Promise* through the following proposed activities (listed by recommendation):

1.1 Advance and implement a Commonwealth of Virginia campaign to reduce the stigma of seeking care and a Virginia strategy for suicide prevention.

Proposed Activity: Virginia proposes to use $200,000 of MHT SIG funds in Year 1 (and $210,000 thereafter) for DMHMRSAS to develop and implement a comprehensive statewide public education campaign to raise awareness and understanding of mental illness, further integrate behavioral health with primary health care, reduce stigma, reduce and prevent suicide, and encourage help-seeking by mental health consumers, parents and families.

DMHMRSAS will convene a Public Awareness and Education Committee with consumer, family and professional representatives to organize and launch the statewide campaign and related efforts. The Committee will ensure that a "Vision focused" theme for the comprehensive campaign is developed and used consistently in any media, agency web sites, and printed materials. Informational materials will be distributed via web-based technology, video news releases, etc. Public awareness activities will be coordinated with other training efforts, including those undertaken by the academic Centers of Excellence (see Objective 5.3, below), the Mid-Atlantic Addiction Technology Transfer Center (at Virginia Commonwealth University), and consumer and advocacy organizations. Increased public awareness of mental illness and its effect on individuals, families and communities is expected to result in more support for mental health care.

DMHMRSAS and the Public Awareness and Education Committee will adopt a national anti-stigma campaign, such as the *CMHS Anti-Stigma Poster Kit* or the National Mental Health Association anti-stigma campaign, to implement statewide with public and private behavioral health providers, schools and general healthcare providers. This approach includes consumer and advocate training; dissemination of public service announcements and literature; training for treatment professionals; and addressing issues specific to co-occurring mental health and substance use disorders. The Committee will contract with consumers and consumer organizations to implement training whenever possible.

Regarding suicide prevention, Virginia has already developed a comprehensive *Suicide Prevention Across the Life Span Plan for the Commonwealth of Virginia*[8]. The Virginia Department of Health (VDH), DMHMRSAS, and a broad stakeholder group, including consumers and suicide survivors, worked together to complete this *Plan* and sought funding for implementation in the 2005 Session of the Virginia General Assembly. Funding was not appropriated, but legislation was enacted designating DMHMRSAS as the lead agency for suicide prevention in the Commonwealth. DMHMRSAS intends to again pursue funding for implementation of the *Plan*.

The *Plan*, which is based on the *National Strategy for Suicide Prevention: Goals and Objectives for Action*[9], includes specific strategies to reduce suicide prevention-related stigma, including public awareness initiatives to raise recognition of the importance of disclosing mental health symptoms to family, friends, or health care professionals and obtaining care for these problems. A companion goal in the *Plan* is to disseminate suicide-related information, including prevention strategies, common signs and symptoms, and information for community involvement. These components will be incorporated into the public education campaign funded through the MHT SIG.

To address stigma related to suicide prevention, DMHMRSAS will work with the existing Virginia Suicide Prevention Steering Committee to develop an education plan for regional/local coalition members and other leaders on the problem of suicide and its prevention. DMHMRSAS will also collaborate with consumer groups and a university, and obtain technical assistance from the CDC, to develop an intensive, comprehensive strategy to develop suicide prevention and awareness programs for areas with high rates of suicide. The Steering Committee will meet with state representative, leaders of family, youth, elderly, and other community service organizations to educate them about the problem of suicide and provide materials for the promotion and integration of suicide prevention components into their programs.

1.2 Address mental health with the same urgency as physical health.
Proposed Activity: Virginia's comprehensive suicide prevention *Plan* described in Objective 1.1 includes a strategy to increase the primary care practitioners who can assure accurate diagnosis, treatment and follow-up for suicidal behavior, depression, substance abuse and other mental disorders. Virginia's use of MHT SIG funds will build upon current efforts to implement a comprehensive public education and awareness campaign that will focus on the importance of mental health to overall health, and on integrating behavioral health and primary health care.

Health care providers need a better understanding of mental illness and recovery-oriented practice so that their interventions can support good health and recovery for persons with mental illness and their families. Workforce development activities provided through the Centers of Excellence and supported by MHT SIG funds (see Objective 5.3 below) will include a focus on working with health care providers to strengthen Virginia's capacity to promote health and recovery through individualized plans of care for consumers that cross all providers.

2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
Proposed Activity: The State MHMRSAS Board Evaluation Committee is presently reviewing State Board policies to eliminate outdated policies, update others and add new ones. One proposal that will be considered at the committee's June meeting is to develop a policy on consumer involvement that will establish a clear commitment to and expectation of consumer involvement in all aspects of the mental health care system.

Virginia will adopt a strict requirement that half of the members of the Transformation Working Group, as well as any affiliated subcommittee, task force, or project steering committee or other team associated with any MHT SIG grant, be composed of consumers, family members and advocates. Virginia proposes to earmark $125,000 of MHT SIG funding annually to Virginia's

Consumer Empowerment and Leadership Training (CELT) program to help prepare consumers to assume active roles in these policy and planning bodies. Additionally, $100,000 will be set aside in year 1 for stipends to support consumer participation on the Transformation Working Group and in the Comprehensive Mental Health Plan development process.

2.3 Align relevant Federal programs to improve access and accountability for mental health services.

Proposed Activity: Virginia will devote $35,000 through a contract with NASMHPD Research Institute to complete the needs assessment and resource inventory for the TWG. In addition, Virginia is allocating $160,000 in Year 1 to hire contracted project specialists and to support specialized studies and projects for the TWG and the Comprehensive MH Plan. The objective of these activities is to identify and integrate policies and funding streams across agencies to support self-directed care and to further develop service capacity for the primary community supports of housing, income supplements, employment, and healthcare.

2.4 Create a Comprehensive State Mental Health Plan.

Proposed Activity: As described below, Virginia will allocate a significant portion of the MHT SIG resources toward development of the Comprehensive Mental Health Plan through investments in the TWG Chair and staff as well as investments in training focused on transformation capacity-building, leadership and other relevant learning experiences for the TWG and key participants to successfully engineer change. Funds are allocated for specialized projects or temporary staff to support the TWG on specific issue analyses, projects, and other tasks. In addition, funds are earmarked for completion of the detailed cross-agency Needs Assessment and Resource Inventory required by the MHT SIG, as well as implementation of a statewide, cross-agency assessment of cultural competency and a plan for strengthening and monitoring cultural competency of Virginia's mental health care system after the first grant year.

2.5 Protect and enhance the rights of people with mental illness.

Proposed Activity: The *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* are currently undergoing revision. An advisory committee made up of consumers, family members, providers and professionals is providing recommendations on the changes to the regulations. The DMHMRSAS Vision is a primary source of guidance for the revision process.

3.1 Improve access to quality care that is culturally competent.

Proposed Activity: Virginia proposes to utilize MHT SIG funds ($60,000 in Year 1) to enter into a contract with the National Association of State Mental Health Directors Research Institute (NRI) to assist Virginia and the Mental Health Transformation Working Group in developing, implementing and monitoring a plan to enhance the cultural competency of Virginia's mental health service system. This effort will include a system self-assessment (including providers, consumers and families); data analysis; design and development of a plan to increase cultural competence of the mental health system at state and local levels; and design, development and implementation of a monitoring plan to assess the impact of transformation strategies related to cultural competence.

3.2 Improve access to quality care in rural and geographically remote areas.

Proposed Activity: Virginia will set aside $100,000 of MHT SIG funds to enter into partnerships with Virginia Universities to conduct specialized studies to inform and guide the Mental Health Transformation Working Group and the related Comprehensive Mental Health Plan and related policy-making efforts. A portion of this specialized funding will be earmarked to study of the needs of persons with mental illness in rural and geographically remote areas, and service delivery strategies (including technology) that will improve access to mental health care in these regions. Each project supported by these funds will require consumers, families and providers as partners in the project.

4.1 Promote the mental health of young children.

Proposed Activity: Virginia proposes to utilize $470,000 of MHT SIG funds (2 X $235,000 per center) in year 1, and $700,000 in subsequent years to establish two Centers of Excellence (COEs) in partnership with Virginia universities to integrate research into recovery-oriented practice; disseminate information to consumers, providers and families; coordinate, contract for or provide in-service training and education to providers on recovery-oriented evidence-based and consensus best practices; coordinate program development consultation to agencies; and provide specialized case consultation to the mental health system. One Center of Excellence will focus on youth with emotional disorders and families, while the second Center of Excellence will be dedicated to adults with serious mental illness. Each COE will work in partnership with an Advisory Board to execute its mission, and follow the requirements for consumer and family representation set forth above. A consumer and a parent will co-chair the Advisory Boards of the COE adult services and the COE for youth, respectively. Each COE will support workforce development training provided by consumers and parents where possible.

Among other goals, the COE for youth and families will develop and disseminate information for parents on early signs of mental health problems and what they should do to get help, and provide in-service education on early mental health problems for preschool, kindergarten and elementary level teachers and other caregivers to address the specific needs of young children. The TWG will incorporate a focus on prevention and early intervention programs in preschool, day-care and Head Start programs into Virginia's Comprehensive Mental Health Plan.

4.2 Improve and expand school mental health programs.

Proposed Activity: Virginia proposes to set aside $25,000 in MHTSIG funds in the first year and $50,000 thereafter to provide start-up funds for developing the statewide Family Support Coalition, an umbrella organization of child advocacy groups that will bring together existing community groups, agency representatives, and unaffiliated individuals to advocate for children with mental illness. Also, the Comprehensive Mental Health Plan will include a focus on youth. Developmental goals will include ensuring that every public school has a mental health professional on staff, that every CSB has a cooperative program with schools within its jurisdiction, and that day treatment programs following the model funded by Virginia's State Medicaid Plan are available in every school. The Center of Excellence for youth and families will include a focus on mental health programming appropriate for the public school system.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Proposed Activity: Current activities, including the Policy Academy and the SAMHSA COSIG Grant, will be coordinated with the Comprehensive Mental Health Plan development process, and will be expanded to address services in other agencies (e.g., DOC) and the private sector. Training and workforce development activities under COSIG, some of which are provided through the SAMHSA/CSAT Mid-Atlantic Addiction Technology Transfer Center (located in Richmond, Virginia) will similarly be coordinated with the Centers of Excellence proposed under the MHT SIG initiative.

4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Proposed Activity: Virginia understands the need to promote mental health and substance abuse screening for all ages in primary care settings and our Vision to promote recovery supports this task. As described in Objectives 1.1 and 1.2, Virginia proposes to utilize $200,000 of MHT SIG funds (Year 1) to develop and sustain a public awareness campaign focusing on awareness of mental illness, mental health as a part of good overall health, and reduction of stigma associated with mental health and substance use disorders. In addition, Virginia's public service campaign to address stigma and implementation of our plan to address suicide prevention across the lifespan will bolster the understanding of health care providers to consider mental health as important as physical health.

Training the health and behavioral healthcare workforce is critical to achieving a recovery-oriented system and the capability to deliver quality mental health and medical care in multiple specialty and service delivery settings. As part of the Centers of Excellence initiative detailed in this proposal, Virginia will identify effective initiatives that can be developed or expanded to increase recognition of depression and SUDs in the elderly, and recognition of and treatment for trauma-related mental health symptoms masking as medical or other conditions in all age groups. Virginia will continue to emphasize the needs of underserved and reluctant populations who access primary care providers to address mental health symptoms via implementation of the SARBI (see Section A, recommendation 4.4), and through the development of the Comprehensive Mental Health Plan.

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

Proposed Activity: Virginia will develop a memorandum of understanding between the Virginia Commonwealth University/Medical College of Virginia, Hampton University, the University of Virginia, and the DMHMRSAS regarding the prioritization of mental health research, and develop a public-academic research plan with key university researchers, consumers, family members and the DMHMRSAS to address barriers to research related to mental health prevention, treatment, and recovery.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create public-private partnership to guide their implementation.

Proposed Activity: As described above (see Objective 4.3) Virginia is implementing a large-scale development and demonstration project through Virginia's COSIG initiative. This project involves development and testing standardized screening protocols for CODs, development and testing of data to support clinical planning and policy-making, and implementation of integrated

treatment for co-occurring disorders at eleven local CSB sites. It also necessitates infrastructure changes that will (among other things) force Virginia's mental health system to be more welcoming, helpful and recovery-oriented in its interactions with all consumers.

Virginia will also create two System of Care demonstration sites with the $1,000,000 appropriated for that purpose in FY 2006 (see Objective 4.2). Virginia has modified the Medicaid requirements for reimbursement of PACT services to provide a mainstream source of funding which will enable PACT teams to be developed and sustained with smaller up-front investment of dollars. DMHMRSAS will continue to explore options for leveraging dissemination of recovery-oriented evidence-based practice through the combined use of targeted start-up (or "bridge") investments and Medicaid.

Through the Co-Occurring Policy Academy initiative, Virginia is working with the state Medicaid agency to enable Medicaid coverage for Medicaid-eligible persons with mental illness who have co-occurring disorders (currently, Virginia Medicaid does not reimburse for most substance abuse treatment).

To address broader workforce and training issues, Virginia also proposes to use $700,000 of MHT SIG funds to develop and operate two Centers of Excellence (COEs) in partnership with Virginia universities, as described in Objective 5.3, below.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

Proposed Activity: Virginia proposes to use $15,000 of MHT SIG funds in Year 1 to contract with NASMHPD Research Institute to assist Virginia in designing and developing two Centers of Excellence. Virginia will use $470,000 of MHT SIG funds to operate the two Centers of Excellence (2 COEs at $235,000 in the first year and $700,000 in subsequent) in partnership with Virginia universities. One COE' mission would focus on children and families, while the second would focus on adults and elderly persons with mental illness. The COEs will focus on (1) integrating current research into recovery-oriented practice; (2) disseminating information to consumers, families, providers and policy-makers about recovery-oriented evidence-based and consensus best practices, (3) coordinating, contracting for and providing training to service providers and others to enhance their knowledge, skills and competencies and strengthen providers' ability to help people recover from mental illness; (4) providing program development consultation to assist organizations and agencies to adopt and support trauma-informed, recovery-oriented, evidence-based practice, and (5) providing specialized case consultation. Each COE will be guided by an Advisory Board of consumers, family members, providers (public and private) and state agency representatives which meets the MHT SIG consumer and family membership requirements (50%) set forth above. Each Advisory Board will be co-chaired by a consumer (COE with adult mission) and a parent (COE with youth and family mission). Each COE will support workforce development training provided by consumers and parents wherever possible.

Additionally, each COE will collaborate with existing training programs for Virginia mental health providers, consumers and families, including :

- The Virginia Human Service Training program (a collaborative program of Region Ten CSB, Piedmont Virginia Community College, the Department of Rehabilitative Services, and DMHMRSAS that provides training for consumers to achieve a Certificate in Human Services to work as peer providers in public agencies whose certificate is recognized by and reimbursable through Medicaid)
- The Consumer Empowerment and Leadership Training (CELT) program (a recovery-oriented training program for mental health consumers operated by the Mental Health Association of Virginia in partnership with the MH Planning Council under contract with DMHMRSAS. CELT provides personal growth opportunities, leadership training and support for consumers to be involved in various roles within the mental health system)
- The Recovery Education and Creative Healing (REACH) program (a recovery-oriented program operated through the Virginia Organization of Consumers Asserting Leadership (VOCAL) in partnership with the MH Planning Council under contract with DMHMRSAS. REACH trains, certifies and supports consumers to teach the Wellness Recovery Action Plan (WRAP) illness management approach to other mental health consumers throughout Virginia)
- The Commonwealth Center for Children and Adolescents (a DMHMRSAS psychiatric hospital for youth that provides training statewide)
- The Institute of Law, Psychiatry and Public Policy at the University of Virginia (a collaborative research and training program focused on criminal and civil mental health legal issues and training)
- The Institute of Child and Family Services (Virginia Commonwealth University- Medical College of Virginia Department of Psychiatry. This is a potential partner for development and operation of the COE for youth and families)
- National Alliance for the Mentally Ill of Virginia, and the SW Virginia Behavioral Health Board (NAMI-VA and the SWVBHB provide family support and education services)
- The SAMHSA/CSAT Mid-Atlantic Addiction technology Transfer Center (funded by SAMHSA/CSAT, DMHMRSAS and Virginia Commonwealth University to provide training in substance abuse and addiction treatment, as well as substance abuse provider certification, throughout the mid-Atlantic area)

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Proposed Activity: Virginia will continue to develop research strategies in partnership with university researchers, agencies, providers, consumers, and family members to conduct further research on key issues for Virginians. DMHMRSAS intends to expand the research related to psychiatric medication to focus on the long-term effects of medications, and to examine further the characteristics that lead to inpatient hospitalization. Virginia intends to use $175,000 of MHT SIG funds in year 1 ($125,000 thereafter) to support these and other research project, and special evaluation studies in support of the Comprehensive Mental Health Plan.

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

Proposed Activity: Virginia will consider establishing a consortium of universities and state agencies to develop a strategic plan to coordinate and expand the use of telepsychiatry in Virginia and to identify research funding and grants that could be used statewide. The

Comprehensive MH Plan will include a structure at the level of the Secretariat for Health and Human Resources to develop a vision for the use of telemedicine in Virginia.

6.2 Develop and implement integrated electronic health record and personal health information systems.

Proposed Activity: With stakeholder collaboration, Virginia will initiate development of preliminary plans for the establishment of a Regional Health Information Organization that will serve as the network through which protected health information will be made available to network providers. Virginia consumers and advocates place a high priority on development of such an "e-vault", not only to enhance care coordination, but to serve as a repository for consumers' psychiatric advance directives, Wellness Recovery Action Plans (WRAPs), and similar information that can promote, enhance and support self-determination and recovery. Virginia will follow all federal standards for technology, security, standardized data sets, and clinical functionalities standards to guide the development of a statewide, integrated electronic health record.

Section D: Proposed Approach:

1. Preliminary Plan to Sustain Transformation:

Virginia's transformation effort is a Comprehensive Mental Health Planning and implementation process designed to create a different, "transformed" system of mental health services. The MHT SIG funds will support a five-year change process that will encompass existing resources and address needs for additional resources. After five years, Virginia intends to have created the infrastructure needed to sustain any transformation processes through the use of new or redirected resources and a strategy for addressing any unmet needs for funds, which will be obtained through the mainstream budget planning process.

Section E: Staff, Management and Relevant Experience

1. Chairperson's Capability to Transform Mental Health System:

James S. Reinhard, M.D., Commissioner of the Virginia Department of MH, MR and SA Services will be the Transformation Working Group Chair. Dr. Reinhard's excellent clinical and administrative qualifications in the mental health field are evident from his biographical sketch (see Section I) and his decade of effective leadership serving the Commonwealth of Virginia. Since 2002, Dr. Reinhard has led the mental health Restructuring activity in Virginia upon which the MHT SIG Transformation effort will be built. He initiated and led the strategic planning process that created a new mission and focus for DMHMRSAS that emphasizes service to customers, partnership and recovery values. Dr. Reinhard is Board Secretary for the National Association of State Mental Health Program Directors, and is highly regarded in Virginia and nationally for "building bridges" among diverse stakeholders. He is the only individual with the credentials, qualifications, credibility and capability to lead transformation in Virginia.

2. Transformation Working Group, Members:

The Transformation Working Group will include James Reinhard, M.D. (Chair), as well as several *ex officio* members representing the major state agencies (and local affiliates) and organizations serving people with mental illness in Virginia. These persons are:

- James Stewart, Inspector General for MH, MR and SA Services, Office of the Governor

- James Rothrock, Commissioner, Dept. of Rehabilitative Services
- Anthony Conyers, Commissioner, Dept. of Social Services
- Patrick Finnerty, Director, Dept. of Medical Assistance Services
- Gene Johnson, Director, Department of Corrections
- Jerrauld Jones, Director, Department of Juvenile Justice
- The Honorable Jane H. Woods, Chair, State Executive Council, Comprehensive Services for At-Risk Youth
- William Shelton, Director, Department of Housing and Community Development
- Laurens Sartoris, President, Virginia Hospital and Healthcare Association

The remaining members of the Transformation Working Group will be nominated by their respective organizations and appointed by Governor Warner upon receipt of the MHT SIG award.

The roles of TWG members will be articulated in the "Transformation Charter Agreement" mentioned earlier. Each agency member of the Transformation Working Group will represent his/her organization and partners (e.g., local affiliates) on the TWG and will serve as liaison to those constituencies. Each TWG member will also lead the transformation effort within their respective organizations and networks, and will be accountable for achieving transformation within their areas of responsibility, as well as outside of their traditional boundaries or silos. Members will be expected to contribute to other members' success in transforming the mental health system in Virginia.

Each TWG member will devote the time necessary to support the transformation process. Pledges of full support and commitment have been received from each TWG member or organization. In the case of state agency members, their respective Cabinet Secretaries have also pledged their support. In addition, agencies and organizations not represented on the TWG have given their full support and commitment to the transformation effort. In summary, Virginia consumers, families, providers, service agencies, legislators and educators have all expressed the highest possible level of support for this effort. Their commitment and contributions are clearly visible in the letters found in Appendix 1, and in the information found in Section H.

3. Staff Under Direction of Transformation Working Group Staff:
The TWG staff includes a Chief of Staff, two Transformation Specialists, two Evaluators, a Financial Manager and an Executive Secretary. These staff will be hired in accordance with Virginia's human resource policies and procedures, and so have not been identified. Summary job descriptions, duties and responsibilities, and qualifications are attached at Section I. To the greatest extent possible, the staff will represent the ethnic and cultural makeup of Virginia. All TWG staff will report to the Chair and will devote full time effort to the transformation process.

4. Timeline for Year One: A timeline for Year 1 activities is shown on the next page.

Work Tasks		**Mental Health Transformation State Incentive Grant -- Project year 1**											
Calendar year ==>		2005			2006								
Month ==>		10	11	12	1	2	3	4	5	6	7	8	9
ID	Task Name												
1	New Virginia Governor Elected & Governor's inauguration												
2	Governor issues Exec Order creating TWG and appoints TWG Chair & committee												
3	Recruit and Hire Key TWG Staff												
4	Transformation Work Group meetings												
5	Transformation charter: development and semi-annual review												
6	Stakeholder meetings and work group tasks												
7	Create Comprehensive Mental Health Plan												
8	Development & strengthening of consumer and parent/family networks across the state												
9	Ongoing Leadership Training for consumers & key transformation leaders												
10	CELT Consumer to Consumer Leadership Training												
11	REACH Consumer to Consumer Wellness Training												
12	Public Education and Anti-stigma Campaign												
13	Develop Cultural Competency plan with NASMHPD/NRI, TWG and stakeholders												
14	Conduct Cross Agency needs assessment and resource inventory with NRI												
15	Develop centers of excellence 1--Assemble advisory boards 2--Negotiate with Universities 3--Specify MOU deliverables, contracts and staff 4--Begin EBP training												
16	Workforce Training to improve knowledge base												
17	Specialized Planning/Studies 1--Rural populations 2--Elderly populations 3--Data Collection 4--Identify issues 5--Develop plans												
18	Evaluation reports to TWG												
19	Prepare recommendations for system and protocol changes based on analyses and strategy identifications												
20	Information Technology Consultants												
21	Technology Enhancements												
22	Semi-annual Report to Governor and Cabinet												
23	Current MH Restructuring (ongoing activities)												

Section F: Evaluation and Data

1. Ability to Collect and Report Required Performance Measures Specified in the NOFA, Including SAMHSA GPRA Data Requirements:

Virginia was able to provide data for 20 of the 21 URS tables for FY 2004. This demonstrates that Virginia has a strong foundation to build on its capacity for data collection. In addition, Virginia already collects data on eight of the ten National Outcome Measures. Virginia will develop methods to collect and report the GPRA measures by the end of Year 1. The Transformation Work Group (TWG) will establish specific goals for each of the GPRA measures for Virginia, as described below for each of the seven GPRA measures (a-g.).

a. **Increase percentage of policy changes completed as a consequence of the Comprehensive Mental Health Plan**
   The TWG will establish a goal for the number of policy changes across the participating agencies and will monitor quarterly the number of changes achieved.

b. **Increase number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the Comprehensive Mental Health Plan**
   The TWG will develop and implement a mechanism to track the number of individuals trained and will document quarterly progress made.

c. **Increase percentage of financing policy changes completed as a consequence of the Comprehensive Mental Health Plan**
   The TWG will establish a goal for the number of financing policy changes across the participating agencies and will monitor quarterly the number of changes achieved.

d. **Increase percentage of organizational changes completed as a consequence of the Comprehensive Mental Health Plan (CMHP)**
   The TWG will establish a goal for the number of organizational changes to be achieved across the participating agencies through the CMHP and will monitor quarterly the number of changes achieved.

e. **Increase the number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan**
   The TWG will establish a baseline for the number of organizations obtaining and analyzing data related to the CMHP and will monitor quarterly the progress made.

f. **Increase the number of consumers and family members that are members of statewide consumer- and family-run networks**
   The TWG will develop and implement a mechanism for monitoring and reporting the umber of consumers and family members participating in the networks.

g. **Increase the number of programs that are implementing practices consistent with the Comprehensive Mental Health Plan.**
   The TWG will establish a baseline for the number of programs implementing practices consistent with the CMHP and will monitor and report quarterly on progress made.

2. Additional Evaluation Measures
Since future evaluation measures will be driven by the goals and recommendations identified in the Comprehensive Mental Health Plan, most of the measures identified below are process measures.

Goal 1: Americans understand that mental health is essential to overall health.

- Develop and implement a comprehensive statewide public education campaign with specific focus areas on anti-stigma, suicide prevention, importance of mental health to overall health, and on integrating behavioral health and primary health care and report the number of activities engaged in.
- Report the number of activities that the education campaign engages in.

Goal 2: Mental health care is consumer and family driven.

- Propose a policy on consumer involvement that will establish a clear commitment to and expectation of consumer involvement in all aspects of the mental health care system.
- Report the number of consumers, family members of consumers, and/or advocates that are on the Transformation Working Group and any affiliated subcommittee, task force or project team. The goal is for half the seats to be made up of consumers, family members, and/or advocates.
- Virginia already collects data on housing and employment status. DMHMRSAS will work with CSBs to improve the data quality of these data elements in year 1 and establish a baseline of number of consumers in stable housing and number of consumers employed. This will continue to be measured each successive year.
- Develop and implement a comprehensive cross-agency Needs Assessment and Resource Inventory and incorporate the results into the Comprehensive Mental Health Plan.
- Develop the Comprehensive Mental Health Plan required by the grant.
- Develop and disseminate a consumer friendly version of *The Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services*.
- Annually, complete and report the results of the Administrative-Data Profile of the Recovery Oriented System Indicators survey for the Commonwealth of Virginia. See Appendix 2 for a copy of the instrument.

Goal 3: Disparities in mental health services are eliminated.

- Continue to implement and report the Adult MHSIP Consumer Survey and the Youth Services Survey Family (YSS-F) on an annual basis. The TWG will utilize survey results to monitor progress towards Virginia transformation and GPRA goals.
- Develop and implement a cross-agency assessment of cultural competency in year 1. In year 2, develop a plan for strengthening and monitoring cultural competency of Virginia's mental health care system. Continue monitoring in subsequent years.
- Through use of Virginia's Community Consumer Submission (CCS) individualized consumer database, the TWG will monitor utilization patterns across the state. This data will be integrated into a GIS system that includes census data. Data on service utilization and outcomes (including inpatient hospitalization rates) will be tracked to assess care in rural and geographically remote areas.

Goal 4: Early mental health screening, assessment, and referral to services are common practice.

- In partnership with Virginia universities, develop two Centers of Excellence (COEs) to provide a source of research, training, education and specialized consultation to Virginia's mental health system. One of the proposed COEs will focus on the mental health needs of children and adolescents and one on adults with serious mental illness. Progress on the activities required to develop the COEs will be reported quarterly.
- Develop a family coalition, "Family Voices of Virginia" (FVV), to serve as an umbrella coalition to bring together existing consumer and community groups, agency representatives, and other interested stakeholders to advocate for children with mental illness. Empanel a statewide working group to implement the development of FVV and report on its progress quarterly and annually.
- Participate with SAMHSA's Co-Occurring State Incentive Grant (COSIG) partnership to improve the screening and assessment of persons with co-occurring disorders and enhance linkages to integrated treatment. Report quarterly and annually on the Commonwealth's progress at improving the screening and assessment of adolescents and adults with co-occurring disorders and the number of clinicians trained to provide integrated mental health and substance abuse treatment.

Goal 5: Excellent mental health care is delivered and research is accelerated.

- The Transformation Work Group's success in convening representatives from Virginia Universities to develop and promote a consumer- and recovery-focused research agenda will be monitored and reported annually.
- The TWG will document and monitor changes in policy and research agendas across participating Virginia universities. Efforts to promote and accelerate research promoting recovery and resilience will be documented.
- A mechanism to document the number of consumers and professionals trained in EBPs will be developed and implemented by the end of year 1. Once the mechanism is operating, reports to the TWG will be made quarterly.
- Changes in reimbursement formulas for EBPs (Medicaid and other insurance) will be documented and reported annually.
- The number of EBPs being implemented through Community Service Boards and consumer run programs (and NAMI and MHAV) will be documented annually.
- The number of consumers receiving EBPs will be reported annually.
- Efforts to promote EBPs throughout the service system and in policy will be documented and reported annually.
- Each of the Centers of Excellence (COE) will document the results of their initiatives, including: numbers in the workforce trained, consumers employed, partnerships initiated, policies changed, media coverage for activities.

Goal 6: Technology is used to access mental health care and information.

- Establish a state-level Telehealth Technology Work Group comprised of consumers, staff from the Virginia Department of Health, DMHMRSAS, the Virginia Information Technology Agency, and representatives from a Virginia medical school to oversee and evaluate telehealth initiatives to be undertaken as a part of the Mental Health Transformation

State Incentive Grant. Report quarterly and annually on the activities and progress of the work group.

- In collaboration with the Virginia Department of Health, pilot-test an integrated electronic health record at the local level to evaluate the technology's potential and serve as the basis for future planning. Report quarterly on the activities undertaken to implement the pilot test, and report outcome(s) achieved at the test's conclusion.

3. Methods for Data Collection:

Progress made on process measures will be documented and reported to the TWG either quarterly or annually. Each sub-committee or workgroup will establish a mechanism to collect the relevant data and report via email their progress on the identified measure. Data collection methods to be utilized include: surveys (paper, phone, face to face, etc.), focus groups, review of documents, meeting minutes, published articles, reports of individuals trained or served, databases maintained to track performance and outcomes. Process measures will be summarized and reported by individuals responsible for reporting to the Transformation Work Group.

Data for the DIG grant from state psychiatric hospitals is collected through a web-based patient management system, AVATAR PM. CSBs maintain independent databases using various systems for client tracking, reporting and data analysis. In addition, the DMHMRSAS Central Office maintains a system to collect data from the CSBs Community Consumer Submission (CCS) system, an MS-SQL Server 2000 database. The Department's Office of Information Technology Services will manage this data. The MHSIP Adult Consumer Survey is distributed to all adults who present for scheduled mental health services during a designated week and are submitted anonymously to a University Research Center. The YSS-F survey is mailed to randomly selected subjects. The data collection process for measuring the GPRA measures has not been identified yet but will comply with applicable Virginia privacy regulations and Federal HIPAA requirements.

4. How Collection, Analysis and Reporting of Performance Data will be integrated into the Evaluation Criteria

The overarching goal for the evaluation component of the transformation initiative is to document the progress made toward achieving the goals of the President's New Freedom Commission and reporting GPRA measures. A Continuous Quality Improvement (CQI) model will be utilized to fully integrate information from the evaluation activities into the activity of the Transformation Work Group. A continuous "self-correcting" feedback process will document progress made toward identified goals. As indicated through the feedback process, the implementation strategies, work plans and resources will be adjusted as needed to improve goal attainment.

Data quality reports will be examined to ensure that information submitted to CCS will fully capture data required for completion of the URS tables. Data for the GPRA measures will drive grant activities for subsequent years. A quarterly report of progress on evaluation criteria will be prepared for the Transformation workgroup and other stakeholders for feedback. Feedback obtained on the results will be integrated into the evaluation plan.

5. Evaluation Personnel:
Two Evaluation Specialists will be hired with MHT SIG funds, and an additional $175,000 is set aside in Year 1 ($125,000 thereafter) to support MHT SIG evaluation functions outlined above through contractual projects and personnel, as determined by the Transformation Working Group. Participating state and local agencies will provide data to the Transformation Working Group as indicated with existing resources.

Section G: Literature Citations

1. Secretary of Health and Human Resource. Suicide Prevention Across the Life Span Plan for the Commonwealth of Virginia. Richmond: Commonwealth of Virginia. Virginia Senate, Document No. 17. (2004).

2. U.S. Department of Health and Human Services–Substance Abuse and Mental Health Services Administration. (2001). *National Strategy for Suicide Prevention: Goals and Objectives for Action*: Inventory Number SMA01-3517. Washington, DC: U.S. Government Printing Office. Retrieved May 23, 2005 from http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp.

3. Olmstead v. L.C. ex rel. Zimring 119 S.Ct. 2176 (1999).

4. Fornili, KS. (Ed.). (2004). *Substance Abuse Tool Box: Information for Primary Care Providers, 2nd Edition.* Richmond, Virginia: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

5. US Department of Health and Human Services. (1997). *A Guide to Substance Abuse Services for Primary Care Clinicians,* Treatment Improvement Protocol (TIP) Series #24. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment.

6. Institute of Medicine. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press.

7. U.S. Census Bureau. (2000). Census of Population and Housing, Summary Tape File 2;" Retrieved May 16, 2005 from American Factfinder; http://www.census.gov/main/www/cen2000.html.

8. Ibid.

9. Ibid.

Section H. - Budget Justification, Existing Resources and Other Support for MH Transformation Grant

	No of FTEs	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Salary							
Chair Person	1	170,000	175,100	180,350	185,765	191,340	
Chief of Staff	1	100,000	103,000	106,090	109,275	112,550	
2 Transformation Specialists @ 75,000 each	2	150,000	154,500	159,135	163,910	168,830	
1 Executive Secretary	1	35,000	36,050	37,130	38,250	39,390	
2 Evaluation Specialists @ 75,000 each	2	150,000	154,500	159,135	163,910	168,830	
1 Financial Manager To track and account for braided funding, monitor budgets and prepare reports for the workgroup	1	65,000	66,950	68,960	71,030	73,160	
Total Personnel (COLAs @ 3% per year)	7	**670,000**	**690,100**	**710,800**	**732,140**	**754,100**	**3,557,140**
Fringe Benefits (32.5%)							
Chair Person		43,870	45,190	46,545	47,940	49,380	
Chief of Staff		30,398	31,310	32,250	33,220	34,210	
2 Transformation Specialists		51,171	52,705	54,290	55,910	57,595	
1 Executive Secretary		17,885	18,420	18,975	19,545	20,130	
2 Evaluation Specialists		51,172	52,705	54,290	55,910	57,595	
1 Financial Manager		23,660	24,370	25,100	25,855	26,630	
Total Fringe Benefits		**218,156**	**224,700**	**231,450**	**238,380**	**245,540**	**1,158,226**

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Travel						
Out of state trips for 20 attendees to conferences on best practices, meetings with other states on transformation etc, including 2 grantee meetings for at least 5 persons each; Air fare $700 per trip X 20	14,000	14,000	14,000	14,000	14,000	
Per diem for hotel and food @150 X3 days X20	9,000	9,000	9,000	9,000	9,000	
Registration estimated at $300 X 20	6,000	6,000	6,000	6,000	6,000	
Local Travel						
For staff and TWG members to travel to various meetings and training throughout the state 35,000 miles X .325 per mile	11,375	11,375	11,375	11,375	11,375	
Per diem for hotel and food (est $75+45 = 120 per day) $120 X 200 trips	24,000	24,000	24,000	24,000	24,000	
Total Travel Costs	**64,375**	**64,375**	**64,375**	**64,375**	**64,375**	**321,875**
Equipment (1)						
Desk, desk chair, side chair, file cabinet, bookcase, computer, cell phone, phone for 7 FTEs X 4,265	29,855	-	-	-	-	
Total Equipment Costs	**29,855**	**-**	**-**	**-**	**-**	**29,855**

Supplies	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Office Supplies $600 X 7, slightly more in years 2,3,4,5	4,200	8,704	8,104	8,100	8,100	
Computer software $300 X7 + $600 X 4	4,500	-	-	-	-	
Total Supplies	**8,700**	**8,704**	**8,104**	**8,100**	**8,100**	**41,708**
Contractual						
Leadership development and training for TWG and stakeholders	75,000	50,000	50,000	50,000	50,000	
Cultural Competence Assessment and Planning (NRI)	60,000	20,000	20,000	20,000	20,000	
Consumer Empowerment and Leadership Training (CELT)	125,000	125,000	125,000	125,000	125,000	
Recovery Education and Creative Healing (REACH) training	50,000	50,000	50,000	50,000	50,000	
Contracted Project Specialists for studies, planning, and other tasks	160,000	90,000	90,000	60,000	35,000	
MH needs assessment and resource inventory (NRI)	35,000					
Public awareness and education campaign – anti-stigma and suicide prevention	200,000	210,000	210,000	210,000	210,000	
Information technology consultants and contracted tech enhancements	125,000	125,000	125,000	125,000	125,000	
Planning for Centers for Excellence (NRI)	15,000					
Contracts to establish 2 University Centers for Excellence (adult and youth) year 1=235,000 each; years 2,3,4,5=350,000 each	470,000	700,000	700,000	700,000	700,000	
Additional public/academic partnership projects and studies (rural, geriatrics, etc.)	100,000	75,000	50,000	50,000	50,000	
VOCAL Executive Director ($50K) and Family Support Coalition ($25K year 1; $50K years 2,3,4,5)	75,000	100,000	100,000	100,000	100,000	
Research and evaluation consultants to inform State MH Plan	175,000	125,000	125,000	125,000	125,000	
Total Contractual	**1,665,000**	**1,670,000**	**1,645,000**	**1,615,000**	**1,590,000**	**8,185,000**

Other (3)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Stipends for consumers/family involved in the project to assist in participation	100,000	100,000	100,000	100,000	100,000	
Advertising for positions, food for working lunches printing & copy charges other than public awareness books and periodicals	33,833	32,040	30,190	31,924	27,804	
Total Other	133,833	132,040	130,190	131,924	127,804	655,791
Total Direct Costs	2,789,919	2,789,919	2,789,919	2,789,919	2,789,919	13,949,595
Indirect Costs (2) (7.53% actual indirect costs)	210,081	210,081	210,081	210,081	210,081	
Total Indirect Costs	210,081	210,081	210,081	210,081	210,081	1,050,405
Total Grant Budget (Federal Funds)	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	15,000,000
In-kind cost sharing (4)						
DMHMRSAS – Director, Office of Mental Health @ 0.4 FTE	41,300	42,539	43,815	45,130	46,483	
Office space @ $12/sq.ft x 150 sq.ft. x 7 MHTSIG staff	12,600	12,978	13,367	13,768	14,181	
Total In-kind cost sharing	53,900	55,517	57,182	58,898	60,664	286,161

Notes: (1) Desk 635, desk chair 300, side chair 145, file cabinet 325, book case 325, computer 1300, cell phone 150 +25 per month, phone 45 +20 per month, printer 500 = 4,265 per employee
(2) The negotiated indirect cost rate is 8.7% however the actual rate was calculated at 7.53% for FY04.
(3) Plus in-kind cost sharing shown below.
(4) The non-transformational duties of Commissioner Reinhard at DMHMRSAS will be paid for by Virginia. Additional resources and supports committed to the project but not costed-out are shown on the following page

Other Resources and Support

The following individuals and the agencies or organizations they represent have committed to actively participate in the Mental Health Transformation project and have offered to contribute the following resources and other support as documented in their letters of support.

Individual	**Agency/Organization**	**Committed Resource**
Governor Mark Warner	Commonwealth of Virginia	Leadership, Direction
Secretary Jane Woods	Health and Human Resources	Leadership, Direction
Raymond Bridge	Mental Health Planning Council	Advice, Oversight of MH resources
Ray Ratke	Department of MH, MR and SA Services	Collaboration and staff support
Cynthia Power	Virginia Organization of Consumers Asserting Leadership (VOCAL)	Consumer Advocates, Communication Network of consumers
Julie Stanley	Office of Community Integration for People with Disabilities (Olmstead)	Statewide collaboration among disability advocates and service providers
James W. Stewart	Office of Inspector General	Ongoing inspections/evaluation of services and facilities
B. Hunt Gunter	State MH, MR and SA Services Board	Planning, Policy formulation
Secretary Michael Schewel	Commerce and Trade	Collaboration
Secretary Pierce Homer	Transportation	Collaboration
Secretary Belle Wheelan	Education	Collaboration
Delegate Harvey Morgan	Joint Commission on Health Care	Collaboration
Marilyn Harris	Governor's Office of Substance Abuse Prevention	Community Profile Data Social Indicators Database
James A. Rothrock	Department of Rehabilitative Services	Collaboration and staff assistance
Anthony Conyers	Department of Social Services	Collaboration and staff assistance
Patrick Finnerty	Department of Medical Assistance Services	Collaboration and staff assistance
Jerrauld Jones	Department of Juvenile Justice	Collaboration
Kim McGaughey	Office of Comprehensive Services	Collaboration, staff, data resources
Colleen Miller	Office of Protection and Advocacy	Collaboration and monitoring
Bill Shelton	Department of Housing and Community Development	Collaboration
Nancy Beebe	National Alliance for the Mentally Ill in Virginia	Collaboration
Gene Johnson	Department of Corrections	MOAs with CSBs and DMHMRSAS
Deborah Pugh	Mental Health Association, CELT Program	Collaboration, trained consumers
Edward Goldenberg	Psychiatric Society of Virginia	Collaboration
Suzanne Clark Johnson	Voices of Virginia's Children	Collaboration
Richard Bonnie	Institute of Law, Psychiatry and Public Policy	Collaboration, training, research
Brian Meyer	Virginia Treatment Center for Children, VCU Medical Center	Collaboration, training, evaluation
Robert Cohen	Commonwealth Institute for Child and Family Studies	Collaboration, workforce development
Mary Ann Bergeron	Virginia Association of Community Services Boards	Data, training, public education
Vicky Fisher	Mental Health Association of Virginia	Collaboration

Section I: Biographical Sketches and Job Descriptions
1. Transformation Working Group Chair and Staff

Title: Transformation Working Group Chair Person – James S. Reinhard, M.D.
Reports directly to the Governor. Provides lead supervision to all Transformation Working Group staff.

BIOGRAPHICAL SKETCH:

EDUCATIONAL HISTORY:
Fellowship:
Harvard Medical School — July 1990 - July 1991
Program in Psychiatry and the Law
Massachusetts Mental Health Center, Bridgewater State Hospital
Residency:
Dartmouth Medical School — July 1984 - July 1988
Department of Psychiatry, Hanover, New Hampshire
Medical School:
University of Illinois — July 1980 - June 1984
College of Medicine, Champaign-Urbana, Illinois

PROFESSIONAL EXPERIENCE:
Commissioner — January 2002 – Present
Commonwealth of Virginia, DMHMRSAS

Assistant Professor of Clinical — March 1995 - Present
Psychiatric Medicine – CF, Univ. of Virginia School of Medicine

Assistant Professor of Psychiatry — November 2001 - Present
Medical College of Virginia, Richmond, Virginia

Assistant Commissioner — August 2001 – January 2002
Division of Facility Management, VA DMHMRSAS

Facility Director/CEO — June 1995 – August 2001
Catawba Hospital, Catawba, Virginia

Assistant Professor of Psychiatry — 1991 - 1994
Dartmouth Medical School
Department of Psychiatry, Hanover, New Hampshire

Director of Inpatient Psychiatry — 1991 - 1994
Department of Veterans Affairs
Medical and Regional Office Center, White River Junction, Vermont

HONORS, AWARDS, AND ACTIVITIES:
Distinguished Fellow
American Psychiatric Association — January 2003

Best Newsletter Editorial — May 2003 and May 2005
Honorable Mention

American Psychiatric Association

Mental Health Professional Award March 1999
Mental Health Association of the Roanoke Valley

Secretary, Board of Directors 2003 - Present
NASMHPD

Secretary, Board Member 2001-2002
Psychiatric Society of Virginia

President 1999 – 2001
Southwest Virginia Psychiatric Society

1993 Inpatient Attending of the Year Award June 1993
Department of Psychiatry, Dartmouth Medical School

Examiner for the American Board June 1993 - January 2000
of Psychiatry and Neurology

Board Certified, American Board of Psychiatry and Neurology (1990)

Board Certified, American Board of Psychiatry and Neurology with added qualifications in Forensic Psychiatry (October, 1994 –October, 2004))

Description of duties and responsibilities:
Represents and reports to Governor; leads on all transformation activities; links with all transformation stakeholders; liaison with Virginia media.

Qualifications for position:
Extensive familiarity with public and private mental health systems; leadership in mental health system transformation activities; demonstrated support for meaningful consumer and family participation; history of willingness to take risks in support of change.

Skills and knowledge required:
Demonstrated understanding and commitment to goals and objectives of the *President's New Freedom Commission on Mental Health* and demonstrated skills in promoting collaboration amongst diverse workgroups

Prior experience required:
Leadership in system transformation activities at local, regional and state levels.

Personal qualities:
Ability to promote empowerment and self-determination in work relationships with emphasis on collaboration and shared ownership of outcomes.

Amount of travel and other special conditions:
Frequent travel to meet with diverse stakeholder groups.

Salary range: $150,000 to $175,000 **Hours per week:** 40

Title: Director, Office of Mental Health – James M. Martinez, Jr.
Provides 40% in-kind staff contribution to the MHTSIG project.

BIOGRAPHICAL SKETCH:

EDUCATIONAL HISTORY:

Master of Education (Evaluation Research), 1977
University of Virginia
Bachelor of Arts (English), 1974
Washington and Lee University

PROFESSIONAL EXPERIENCE:

Virginia Dept of MH, MR and SA Services

Director, Office of Mental Health	11/95- Present
Acting Director, Office of Consumer Affairs	10/01-2/02
Acting Director, Substance Abuse Services	11/00-7/01
Director of Adult Services, Office of MH	7/88-11/95
Assistant Director, Office of MH	1/86-7/88
Regional Mental Health Consultant (SWVa), Office of MH	3/82-1/86
Assistant Director, Community Support Unit	2/78-3/82
Evaluation Specialist, Div. of Substance Abuse,	6/77-1/78

HONORS, CERTIFICATES, and ACTIVITIES:

"Living the Vision of Recovery" Award, 2004, presented by MHA of Virginia on behalf of Virginia's mental health consumers and advocates

Leading, Educating and Developing, March 2005, Weldon Cooper Center for Public Service, University of Virginia

Virginia Executive Institute, June 2001, Virginia Commonwealth University Center for Public Policy

Program for Executive Leadership in Mental Health Administration, 1989, JFK School of Government, Harvard University.

Beyond Deinstitutionalization: Developing Community-Based Mental Health Systems, 1980, NIMH Staff College, Philadelphia, PA.

Member (ex officio), 1995-present, *Virginia Mental Health Planning Council* and MHPC Executive Committee

Member, 1993-present, *Committee on the Needs of the Mentally Disabled*, Virginia Bar Association

Associate, 1996-1999, *Institute of Law, Psychiatry and Public Policy*, Univ. of Virginia

Member, 1984-present, *Virginia Psychiatric Rehabilitation Association*, (Co-Founder, Vice President 1984-1986, Board Member 1984-1992)

Board Member, 1992-1995, *On Our Own, Charlottesville, Inc.*

Description of duties and responsibilities:
Leads Office of MH; advances DMHMRSAS vision and transformation activities; liaison to consumer, advocate, provider stakeholders.

Skills and Qualifications to Support Transformation:
Twenty nine years experience in Virginia's public mental health systems; leadership in mental health restructuring and transformation to date; demonstrated support for meaningful consumer and family participation; strong relationships with stakeholders (consumers, providers, legislators, etc); willing to take risks in support of change.

Personal qualities:
Promotes shared vision, collaboration, and mutual interests in work with stakeholders; fosters empowerment and partnership in work relationships.

In-kind Staff

Hours per week: 16

Title: Chief of Staff (Assistant Chair Person)

Description of duties and responsibilities:

Reports to Chair Person. Provide leadership, direction, management and support for the Mental Health Transformation Project including interagency policy development and strategic and operational planning as part of the Transformation Working Group; grant initiatives and contracts development, implementation and management; hiring, development and supervision of Transformation Project staff; management of grant budget; collaboration with state agencies and legislature, providers, consumers, families, advocates and other stakeholders.

Qualifications for position:

Masters degree in psychology, social work, rehabilitation counseling, nursing, or mental health-related field preferred. Minimum ten years supervisory experience in program manager, unit or division manager role in mental health service provider agency or organization; local or state government human service agency, unit or division, or state government human service agency.

Skills and knowledge required:

Considerable knowledge and abilities in:

- Aligning services and supports, policies and practices, financial strategies, and funding incentives;
- Developing or enhancing cross-agency, evidence-based and consensus best practice service capacity for Virginians with mental illness, particularly with respect to housing, employment, education, health, or criminal justice;
- Coordination of policy, budget, and planning functions.
- Structure and operation of community-based mental health systems of care
- Program operations and interventions for persons with mental illness, knowledge of recovery concepts and supports, and knowledge of the support needs of families and consumers with mental illnesses.
- Ability to plan, manage and coordinate multiple and diverse projects.
- Ability to develop and manage large grants, contracts and budgets.
- Excellent communication skills (oral and written).
- Ability to establish and maintain effective relationships with diverse stakeholder groups (agencies, consumers, legislators, local providers, etc.).
- Ability to motivate, lead and supervise diverse staff.

Prior experience required:

Substantial experience in management of mental health systems of care and cross-systems/cross-agency collaboration.

Personal qualities:

Ability to promote empowerment and self-determination in work relationships with emphasis on collaboration and shared ownership of outcomes.

Amount of travel and other special conditions:

Frequent travel to meet with diverse stakeholder groups.

Salary range: $90,000 to $110,000 **Hours per week:** 40

Title: Transformation Specialists
Description of duties and responsibilities:
Report to Chair Person. Serve as mental health transformation and systems integration coordinators, including identifying stakeholders and assisting them in their active participation, staffing Transformation Working Group and other interagency meetings, acting as a liaison between mental health and other systems, coordinating the development and management of the Transformation Charter Agreement, memorandum of understanding, and other contracts and joint proposals, and providing overall assistance for implementing mental health transformation and systems integration.

Qualifications for position:
Masters degree in psychology, social work, rehabilitation counseling, nursing, or mental health-related field preferred. Minimum five years supervisory experience in program manager, unit or division manager role in mental health service provider agency or organization; local government human service agency, unit or division; state government human service agency.

Skills and knowledge required:
Considerable knowledge and abilities in:

- Aligning services and supports, policies and practices, financial strategies, and funding incentives;
- Developing or enhancing cross-agency, evidence-based and consensus best practice service capacity for Virginians with mental illness, particularly with respect to housing, employment, education, health, or criminal justice;
- Coordination of policy, budget, and planning functions.
- Structure and operation of community-based mental health systems of care
- Program operations and interventions for persons with mental illness, knowledge of recovery concepts and supports, and knowledge of the support needs of families and consumers with mental illnesses.
- Ability to manage and coordinate multiple and diverse projects.
- Ability to develop and manage grants, contracts and budgets.
- Excellent communication skills (oral and written).
- Ability to establish and maintain effective relationships with diverse stakeholder groups (agencies, consumers, legislators, local providers, etc.).

Prior experience required:
Substantial experience in management or operations of mental health systems of care and cross-systems/cross-agency collaboration.

Personal qualities:
Ability to promote empowerment and self-determination in work relationships with emphasis on collaboration and shared ownership of outcomes.

Amount of travel and other special conditions:
Frequent travel to meet with diverse stakeholder groups.

Salary range: $70,000 - $80,000 **Hours per week:** 40

Title: Executive Secretary

Description of duties and responsibilities:

Reports to Chair Person. Provides an array of executive administrative, technical and program support to members of the staff and Transformation Working Group. Format and proof correspondence, documents and forms as directed; create charts and graphs in various programs as requested. Maintain leave records, purchase orders for staff; process and edit travel reimbursement vouchers; make arrangements for the Chair Person and staff. Develop and maintain staff, membership, and constituency lists.

Qualifications for position:

Proficient advanced computer skills with various program/software to include Windows, MS-Word, 2000 WP-8, MS Exchange, Outlook, Excel, PowerPoint, and Access.

Skills and knowledge required:

Extensive knowledge and operating skills for executive secretarial/administrative assistance duties.

Prior experience required:

Considerable experience in executive secretarial/administrative assistance duties with multiple managers.

Personal qualities:

Flexibility and commitment to project goals and objectives.

Amount of travel and other special conditions:

Some in-state travel required for regional meetings.

Salary range: $30,000 to $40,000 **Hours per week:** 40

Title: Evaluation Specialists

Description of duties and responsibilities:
Report to Chair Person. Responsible for providing quantitative and qualitative evaluation expertise to Mental Health Transformation staff and Working Group and lead the development and implementation of process and outcome measures in support of Virginia's Transformation goals and objectives and the SAMHSA GPRA measures.

Qualifications for position:
A PhD or graduate-level coursework/training in research methods, program evaluation, statistics, and computer-assisted data management and analysis. Work experience with public and private mental health systems; ability to provide process and outcome evaluation leadership in mental health system transformation activities; demonstrated support for meaningful consumer and family participation in designing, implementing and analyzing evaluation information; ability to integrate quality improvement principles into transformation processes in support of change.

Skills and Knowledge required:
- Strong verbal and written communication skills
- Ability to work independently and as a member of a team
- Ability to work with the consumer community and with culturally diverse populations
- Knowledge of the President's New Freedom Commission goals and objectives
- Knowledge of behavioral health principles and practices
- Knowledge of process and outcome evaluation practices
- Knowledge of continuous quality improvement principles and practices
- Skilled in the use of computer software products (Word, Excel, Access, PowerPoint, Visio, Project Management and SPSS)

Prior experience required:
Significant experience conducting process and outcome evaluations in the public sector and work experience in behavioral health, in state government and with the consumer community.

Personal qualities:
Strong work ethic with proven ability to work with diverse populations in a teamwork environment.

Amount of travel and other special conditions:
Primarily in state day travel with some overnight

Salary range: $70,000 - $80,000 **Hours per week:** 40

Title: Financial Manager

Description of duties and responsibilities:
Reports to Chair Person. Responsible for overall funds management and financial reporting for the Mental Health Transformation Project including managing and reporting fiscal data to meet the needs of the Transformation Working Group, providing consultation and technical assistance to project members on potential strategies for braiding and blending various state and federal funding streams, controlling funds according to federal and state rules and regulations, timely and accurately recording and reporting of funds according to Generally Accepted Accounting Principles.

Qualifications for position:
Bachelor's of Science Degree in Accounting, Finance, Business Administration, or related field with advanced degree preferred; Certified Public Accountant.

Skills and knowledge required:
Extensive knowledge and experience in State Budgeting, Government Accounting, managing Federal Grants and related rules and regulations,

Prior experience required:
Extensive experience in managing Federal Grants, financial reporting, and working in an organization(s) with complex financial activities.

Personal qualities:
Conscientious and professional manner with diverse coworkers and constituents.

Amount of travel and other special conditions:
Occasional travel in state required for meetings and consultations.

Salary range: $60,000 - $70,000 **Hours per week:** 40

2. Other Key Stakeholders

Title: President, Mental Health Planning Council of Virginia, Raymond Bridge

BIOGRAPHICAL SKETCH:

EDUCATIONAL HISTORY:
BA, English, Oberlin College

PROFESSIONAL EXPERIENCE:
Professional work:
Peer service provider and mental health advocate
Public Information Officer for federal government agency

Community Involvement
President, Mental Health Planning Council
Olmstead Citizen Oversight Committee for Implementation
Consumer leader in the design of the Medicaid buy-in program
Secretary, Virginia Organization of Consumers Asserting Leadership
Team leader – VOCAL application to CMHS to start a statewide mental health consumer network
Founder & President – Laurie Mitchell Employment Center
Partner in Dept of Labor grant to help One-Stop employment centers serve persons with disabilities
Founding member and President – Northern Virginia Mental Health Consumers Association

Title: Director of REACH (Recovery Education and Creative Healing), Mary J. McQuown

BIOGRAPHICAL SKETCH:

EDUCATIONAL HISTORY:
BS, Business Administration/Accounting, Eastern Oregon State College, La Grande, OR - 1986
MA, Business Management, Regent University Chesapeake, VA, 2002
MA, Practical Theology, Regent University Chesapeake, VA, 2004

PROFESSIONAL EXPERIENCE:
Professional work:
WRAP (Wellness Recovery Action Plan),
DRADA Support Groups (Depression & Related Affective Disorders Association),
Self-Help Clearing House Freedom Self-Advocacy Curriculum,
MESA (Mutual Education Support and Advocacy), and
Family to Family.

I am also a graduate of CELT Leadership Academy.

Community Involvement:
- Founding member: POP (People of Power), consumer-run, recovery-based education and support organization using WRAP
- Member: CELT (Consumer Empowerment Leadership Training) Steering Committee
- Member: Mental Health Planning Council
- Member: Board of Directors, Chesapeake Community Services Board
- Past President: Alliance for the Mentally Ill of Chesapeake

Title: Director, Consumer Empowerment & Leadership Training (CELT), Deborah Pugh

BIOGRAPHICAL SKETCH:

EDUCATIONAL HISTORY:
BS, Sociology, Longwood College, Farmville, VA - 1975
MFA, Writing/Teaching, George Mason University, VA, 1994

PROFESSIONAL EXPERIENCE:
Professional work:
CELT Program Director
Medicaid Social Worker
Police Officer
University Professor
Training Developer and Facilitator
Writer

Community Involvement:
Virginian's Aligned Against Sexual Assault

Title: President, Virginia Organization of Consumers Asserting Leadership, Inc., (VOCAL), Cynthia Power

BIOGRAPHICAL SKETCH:

EDUCATIONAL HISTORY:

PROFESSIONAL EXPERIENCE:
Professional work:
President of VOCAL, Inc

Community Involvement:
Cynthia serves as the President of the Board of Directors of On Our Own, Charlottesville, a consumer-run services center. She serves on the Virginia Mental Health Planning Council and is the former chair of membership. She maintains an affiliation with the Mental Health Association of Charlottesville and the National Alliance for the Mentally Ill – Virginia.

Title: Executive Director, Mental Health Association of Virginia., Vicky Mitchell Fisher, MS, RN, APRN, PhD

BIOGRAPHICAL SKETCH:

EDUCATIONAL HISTORY:
Doctor of Philosophy in Psychiatric Nursing

PROFESSIONAL EXPERIENCE:
Professional work:
RESEARCH AND PROFESSIONAL EXPERIENCE (Starting with present position, list training and experience relevant to the proposed project)

Gubernatorial appointments to the Hammond-Anderson Commission to study Va.'s public mental health system

Vice-chair of the Olmstead Oversight Advisory Task Force.

Serve on the state Mental Health Planning Council.

Research highlights include federal funding of dissertation research through a National Research Service Award (NRSA). Doctoral research course work included courses in Quantitative research methods, Qualitative research methods, and Instrument development, as well as several research assistant ships with mental health projects.

Previously worked as Project Director for Cost Effectiveness on a federally funded study with the Southern Virginia Mental Health Research Center, University of Virginia, "Testing a Cognitive Therapy Intervention for Depressed Women in Rural Settings."

Extensive experience as a provider, in both public and private inpatient and outpatient settings working with all age groups.

Community Involvement:
Member of Sigma Theta Tau (nursing honor society) and Phi Kappa Phi. Member of the International Society of Psychiatric Nursing. Credentialed to do therapy as an advanced practice psychiatric (APNA)nurse through the American Nurses Association (ANA).

Section J: Confidentiality and Participant Protection

Virginia DMHMRSAS places a high priority on consumer data security at all levels of the organization and will adhere to all current provisions of Virginia law governing privacy of consumer records. Security is addressed at each point in the processing, storage, data use, and data transmission process, at both the local and DMHMRSAS levels. Data in all routine reports generated by DMHMRSAS will be in aggregate form. Consumer-specific information will never be a part of formal reports generated. Data collected for the majority of the URS tables is extracted out of existing data sources. The data obtained from secondary databases is de-identified and does not qualify as Personal Healthcare Information. However, all participating organizations adhere to applicable Virginia privacy regulations and Federal HIPAA requirements. Collection of data for the GPRA measures will be designed to adhere to applicable Virginia privacy regulations and Federal HIPAA requirements as well and will not include any Personal Healthcare Information.

Protect Clients and Staff from Potential Risks

Potential Risks: For data extraction, there are no known risks. There is minimal risk associated with completion of the voluntary, confidential satisfaction surveys. In collecting data for the GPRA measures that include counts of persons, all data collected will be in aggregate with no identifying information so there are no known risks.

Risk Reduction: The surveys for the Data Infrastructure Grant URS tables are voluntary and individuals are free to decline to participate and they do not have any personal identifying information on them. Data collected for GPRA measures will not have any personal identifying information on them.

Plans for Guidance in the Event of Adverse Effects: The Department has a strong human rights program to address and resolve any suspected cases breeches of confidentiality and other human rights. Each state hospital has a human rights advocate on site and there are regional advocates for the CSBs. All consumers in state hospitals and local CSBs are notified at admission of their rights and are provided with information about how to contact their local human rights advocate. In addition, the Department maintains a toll free hot line that consumers may use to report any concerns or complaints. All complaints are investigated to determine their validity and to resolve the situation. The cover letter for the surveys includes a telephone number and contact person to respond to any potential adverse effects.

Alternative Treatments/Procedures: No clinical treatments are being evaluated in this project. No treatments are being denied. All consumers will have access to all treatments provided by the mental health system, as appropriate.

Fair Selection of Participants

Target Population: For data collected through data extraction for the Data Infrastructure Grant, the target population is all persons who have received services from the SMHA for a mental health disorder. For the MHSIP consumer survey the target population is all adults who present for scheduled mental health services during a designated week. For the YSS-F survey, the sample is a random, stratified survey of families of children who received mental health services

in a four-month timeframe. For GPRA measures, the target population is mental health staff and mental health consumers across the state of Virginia.

Exclusions: For data extraction for the Data Infrastructure Grant, persons served by the SMHA who do not have a mental health disorder are excluded. For the MHSIP adult consumer survey, adults without a mental health diagnosis and those who do not receive services during the specified week are excluded. For the YSS-F survey, families of children who did not receive services during the specified time frame are excluded. For data collected for the GPRA measures, persons that do not have a mental illness and/or do not work with individuals with mental illness are excluded. Organizations and State Agencies that do not provide any services to mental health consumers are excluded as well.

Recruitment and Selection Procedures: Only individuals who are receiving services administered by the SMHA during a specified time period are included in the Data Infrastructure Grant URS tables. All persons across the state of Virginia who have a mental illness and/or work with individuals with a mental illness are eligible for inclusion data collection for the relevant GPRA measures.

Absence of Coercion

Participation in the surveys for the Data Infrastructure Grant is voluntary.

There is no compensation for participation.

Assurance of Continued Services: Assurance is provided on the survey forms for the Data Infrastructure Grant URS tables that services are not contingent on participation. When applicable, similar assurances will be provided on any data collection instruments for the GPRA measures.

Data Collection

Data Collection Procedures: Primary data collected is extracted from existing databases. The YSS-F survey is mailed to randomly selected subjects. The MHSIP Adult Consumer Survey is distributed to all adults who present for scheduled mental health services during a designated week. The data collection process for measuring the GPRA measures has not been identified yet but will comply with applicable Virginia privacy regulations and Federal HIPAA requirements.

Type of Specimens: There are no specimens collected.

See Appendix 2 for copies of the YSS-F and MHSIP Adult Consumer Survey.

Privacy and Confidentiality

Assurance of Privacy and Confidentiality: The data obtained from secondary databases is de-identified and cannot be linked to any specific person. In addition, all participating organizations adhere to applicable Virginia privacy regulations and Federal HIPAA requirements. Consumer surveys for the Data Infrastructure Grant URS tables are submitted anonymously to a University Research Center. The University Institutional Review Board approved both surveys. There is no identifying information on either survey.

Data Collection Uses: Reports generated from the data are aggregated at the locality, regional and statewide level. No individual level reports will be generated.
Data Storage: All data is kept either in locked cabinets or password protected information systems.

Personnel Access to Information: Only those persons listed in the DIG staffing plan and the contract staff at the University Research Center has access to the data for the Data Infrastructure Grant.

Privacy Procedures: Extracted data is de-identified, as is the MHSIP adult consumer survey. Data received from completed YSS-F surveys is stored separately from any identifying information. Data for the GPRA measures will not include any Personal Health Information.

Consent Procedures
Information Provided to Participants: Participation in survey data collection is voluntary and confidential. Treatment is not contingent upon participation.

Risks: There is minimal risk associated with completion of the voluntary, confidential satisfaction surveys.

Protection From Risks: The cover letter for the surveys includes a telephone number and contact person to respond to any potential adverse effects.

Consent from Particular Groups: Consent is implied by virtue of completing a survey.

Risk/Benefit Discussion
Risks of participating in the project are minimal. Localities, the state and the federal government will benefit from the project by increasing the service system infrastructure.

Appendix 1: Letters of Commitment and Support

Appendix 2: Data Collection Instruments, Protocols

Appendix 3: Sample Consent Forms

There are no Consent Forms enclosed. Virginia does not anticipate using Consent Forms for this grant.

Assurances

Certifications

OMB Approval No. 0920-0428

CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 - 50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: ☐ NEW ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	☒	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☒	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☒	
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
☐ Civil Rights Assurance (45 CFR 80) ..... _____		
☐ Assurance Concerning the Handicapped (45 CFR 84) ..... _____		
☐ Assurance Concerning Sex Discrimination (45 CFR 86) ..... _____		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91) ..... _____		
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☐

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☐
2. Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☐	
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE?	☐	
4. Have biographical sketch(es) with job description(s) been attached, when required	☐	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☐	
6. Has the 12 month detailed budget been provided?	☐	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☐	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☐
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☐

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.

Name Mark R. Warner
Title Governor of Virginia
Organization Commonwealth of Virginia
Address 1111 East Broad Street
E-mail Address
Telephone Number (804) 786-2211
Fax Number (804) 371-6351

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Name James S. Reinhard
Title Commissioner, Dept. of MH, MR, & SA Services
Organization Commonwealth of Virginia
Address 1220 Bank Street
E-mail Address james.reinhard@co.dmhmrsas.virginia.gov
Telephone Number (804) 786-3921
Fax Number (804) 371-6638

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)	**SOCIAL SECURITY NUMBER**	**HIGHEST DEGREE EARNED**